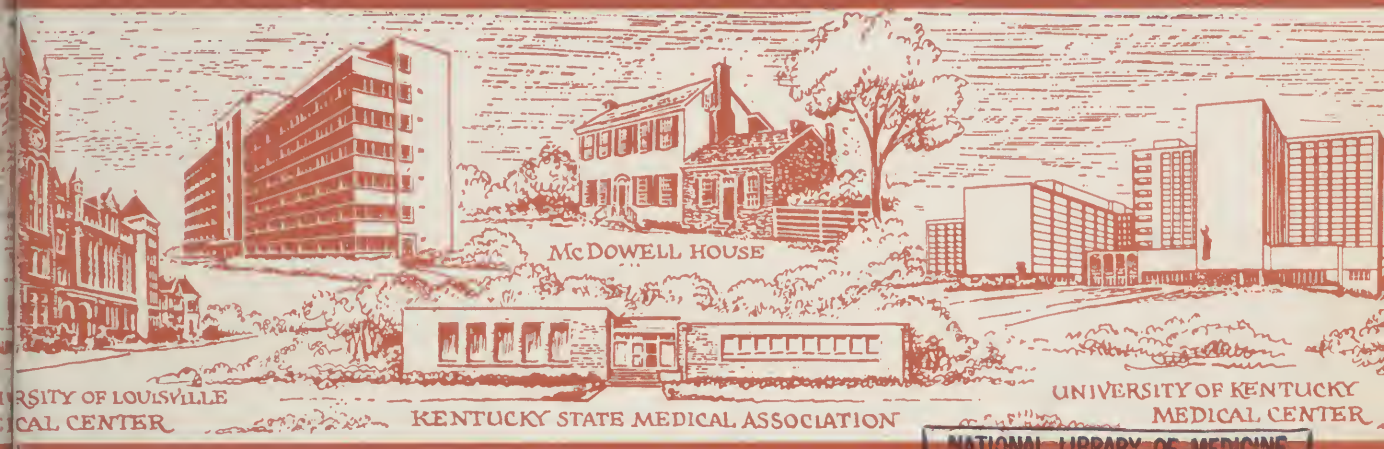
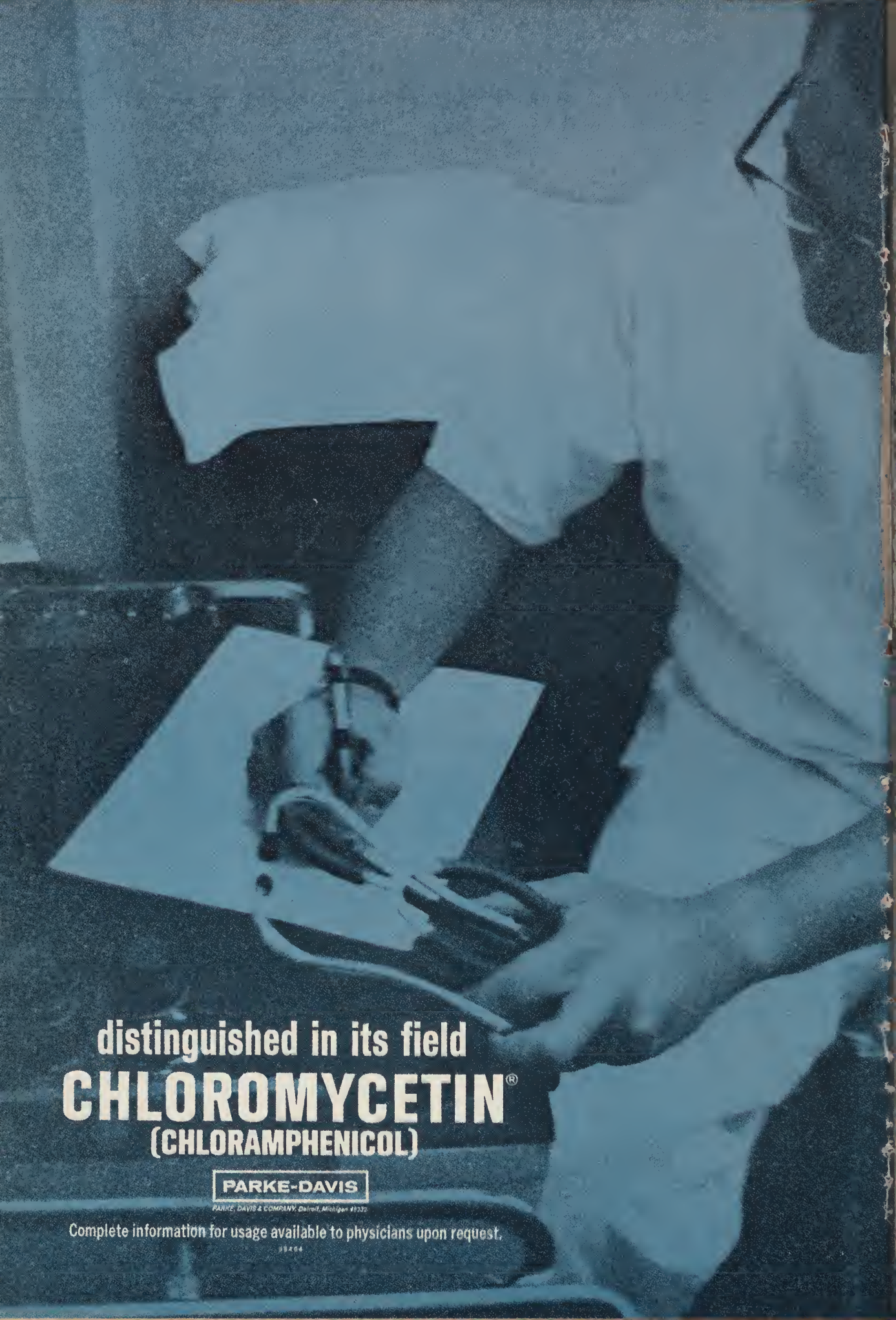
NOVEMBER 1964 • VOLUME 62 • NUMBER 11

THE JOURNAL

OF THE KENTUCKY MEDICAL ASSOCIATION



In This Issue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Each Tablet contains:

ACHROMYCIN® Tetracycline HCl	125 mg.
Acetophenetidin (Phenacetin)	120 mg.
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Each (5 cc.) Teaspoonful of Syrup (lemon-lime flavored) contains:

ACHROMYCIN® Tetracycline equivalent to Tetracycline HCl	125 mg.
Acetophenetidin (Phenacetin)	120 mg.
Salicylamide	150 mg.
Ascorbic Acid (C)	25 mg.
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Effective in controlling tetracycline-sensitive bacterial infection and providing symptomatic relief in allergic diseases of the upper respiratory tract. Possible side effects are drowsiness, slight gastric distress, overgrowth of nonsusceptible organisms, tooth discoloration. The last named may occur only if the drug is given during tooth formation (late pregnancy, the neonatal period, early childhood). Average Adult Dosage: 2 Tablets or 2 Teaspoonfuls of Syrup four times daily. The total average daily dosage for children, determined by the tetracycline content, is 10 to 20 mg. per pound body weight, divided into four equal doses.

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JOURNAL of the KENTUCKY MEDICAL ASSOCIATION

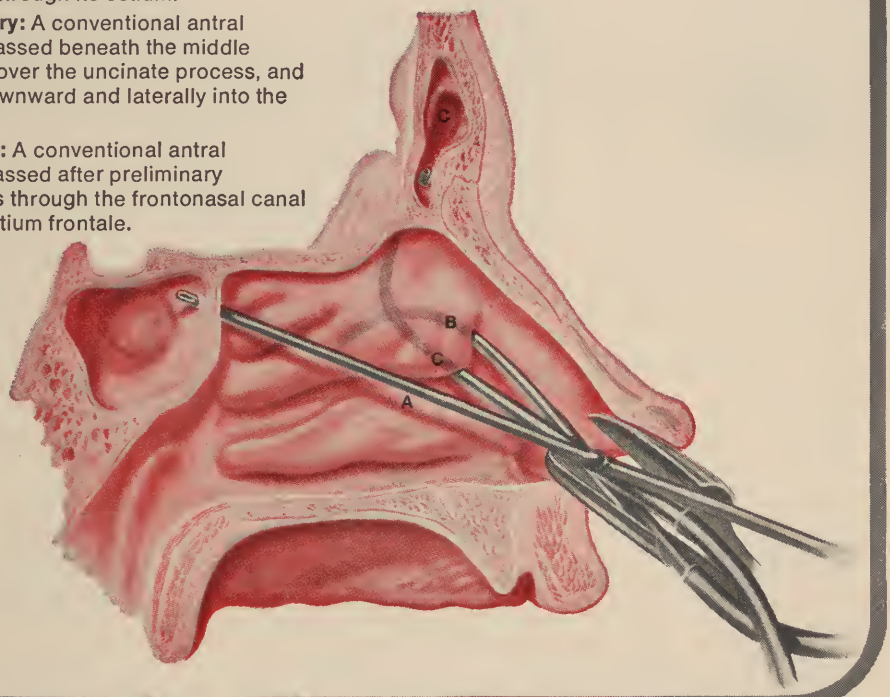
Contents

A rhinologic approach to the sinuses
Sagittal anatomical section of nasal cavity showing approach for probing or irrigation by cannulas.

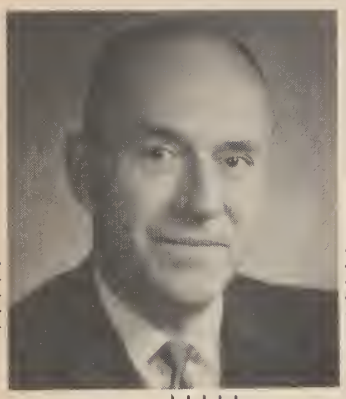
A—Sphenoid: A sphenoid cannula (under 13.5 cm.) passed around the middle and superior turbinates to the anterior wall of the sinus through its ostium.

B—Maxillary: A conventional antral cannula passed beneath the middle turbinate, over the uncinate process, and rotated downward and laterally into the ostium.

C—Frontal: A conventional antral cannula passed after preliminary maneuvers through the frontonasal canal into the ostium frontale.



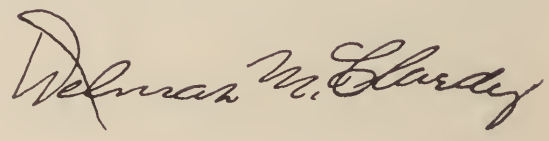
MESSAGE FROM THE PRESIDENT

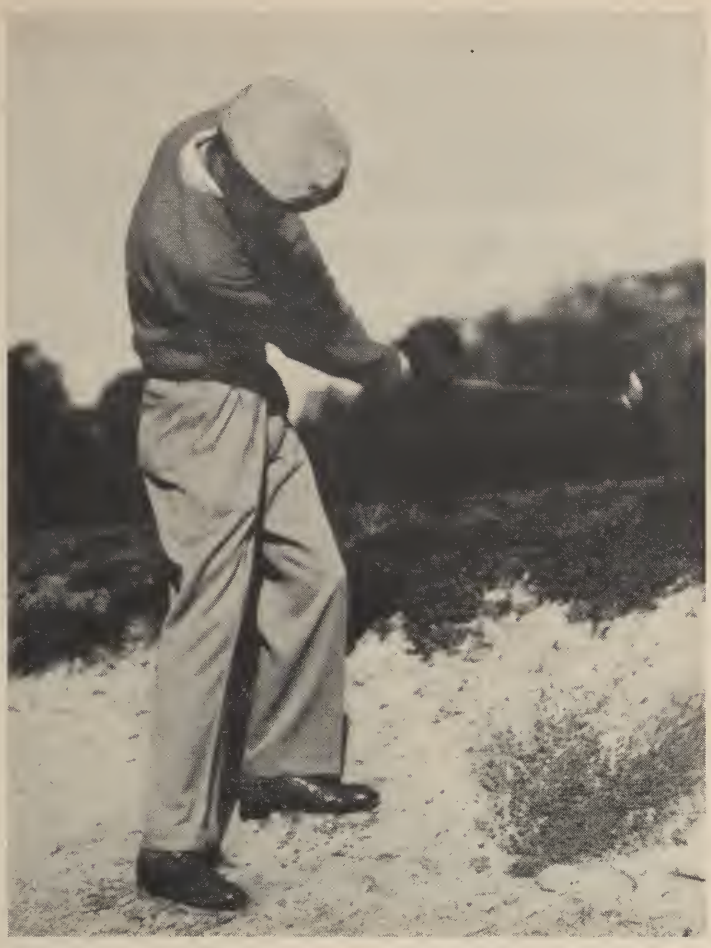


The Purpose of the Kentucky Medical Association

"THE purpose of the Association shall be to federate and bring into compact organization the entire medical profession of the State of Kentucky and to unite with similar associations in other states to form the American Medical Association, with a view to the extension of medical knowledge; the advancement of medical science and charity; the evaluation of the standards of medical education; the enactment and enforcement of just medical laws; the promotion of friendly intercourse among physicians and the guarding and fostering of their material interests; the protection of the members thereof against unjust assaults upon their professional care, skill or integrity; and to the enlightment and direction of public opinion in regard to the great problems of state medicine so that the profession shall become more capable and honorable within itself and most useful to the public in the prevention and cure of disease and in prolonging and adding comfort to life".

The above is Article II of the Constitution of the Kentucky State Medical Association. What better message could be conveyed at this time? It would be well if it could be relayed to our patients and the public in general.





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BRIEF SUMMARY

'SOMA' COMPOUND; 'SOMA' COMPOUND plus CODEINE: carisoprodol, acetophenetidin, caffeine, codeine phosphate. *Warning: Codeine may be habit-forming.* **Indications:** 'Soma' Compound and 'Soma' Compound with Codeine are indicated for relief of pain and stiffness in traumatic, rheumatic and other similar conditions. **Contraindications:** Allergic or idiosyncratic reactions to carisoprodol or codeine. **Precautions:** *Acetophenetidin*—May damage the kidneys when used in large amounts or for long periods. *Codeine*—Should be used with caution in addiction-prone individuals. *Carisoprodol*—Like other central nervous system depressants, should be used with caution in patients with known propensity for taking excessive quantities of drugs and in patients with known sensitivity to compounds of similar chemical structure, e.g., meprobamate. **Side effects:** *Codeine*—Nausea, vomiting, constipation, and miosis. *Carisoprodol*—The only side effect reported with any frequency is drowsiness, usually on higher than recommended doses. One instance each of pancytopenia and leukopenia occurring when carisoprodol was administered with other drugs has been reported as has an instance of fixed drug eruption with carisoprodol and subsequent cross-reaction to meprobamate. Rare allergic reactions, usually mild, have included one case each of anaphylactoid reaction with mild shock and angioneurotic edema with respiratory difficulty, both reversed with appropriate therapy. Other rarely observed reactions have included dizziness, ataxia, agitation, increase in eosinophil count, and gastrointestinal symptoms. Massive overdosage may produce coma and/or mild shock and respiratory depression. **Dosage:** 'Soma' Compound and 'Soma' Compound with Codeine, one or two tablets three times daily and at bedtime. **Supplied:** 'Soma' Compound, orange tablets, each containing carisoprodol 200 mg., acetophenetidin 160 mg., and caffeine 32 mg. 'Soma' Compound with Codeine, white, lozenge-shaped tablets, each containing carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg., and codeine phosphate 16 mg. Narcotic order form required. *Before prescribing, consult package circular.*

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Three tablespoonfuls (45 cc.) contain:		
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Choline†		100 mg.
Inositol†		100 mg.
Calcium glycerophosphate	(2% MDR for calcium and phosphorus)	100 mg.
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Manganese (as sulfate)		1 mg.
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Zinc (as acetate)		1 mg.
Molybdenum (as ammonium molybdate)		1 mg.
Alcohol 15%		

*Multiple of adult Minimum Daily Requirement supplied
†Requirement in human nutrition not yet established

the need for a tonic knows no age

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THE INSURANCE PAGE

Changing Public Attitudes Toward Medicial and Hospital Care

ONE of the many interesting talks given before the recent AMA-sponsored Fourth National Congress on Voluntary Health Insurance and Prepayment was that of Carl E. Anderson, M.D., chairman of the Council of the California Medical Association.

Speaking on the role of the physician in the conservation of the health care dollar, Doctor Anderson stated that medical societies and their prepayment and insurance allies must be made aware of newly emerging socio-economic and philosophical beliefs which are being accepted by the public to an increasing degree.

Whether or not we agree with these ideas, their existence cannot be denied, and medicine must be prepared to cope with them in an informed, rational and dispassionate manner.

Among these beliefs which were mentioned by Doctor Anderson were the following:

. . . The public and each member of it has a right to receive medical care.

. . . It is not socially acceptable for illness to result in personal financial disaster.

. . . Retired people have earned for themselves the right to medical care without pauperizing themselves.

. . . It is undignified to receive charity.

. . . The hospital, regardless of ownership, is a public institution.

. . . The state, as representative of the public, has the right to control the quality and cost of medical and hospital Insurance and Prepayment Plans.

. . . The quality of medical care, both in and out of hospitals, is a legitimate area of public concern.

It was Doctor Anderson's feeling that to assure continued public acceptance of the private and voluntary system of medical practice, medicine must be prepared to assume the leadership in solving the socio-economic problems of today.

In particular, he pointed out that medical support and leadership is needed in voluntary hospital planning at all levels; that medical staffs must be concerned with hospital utilization as a matter of public responsibility; and that medicine should encourage and demand health insurance coverage (on an experimental basis, if necessary) for chronic illness, nursing home care, and psychiatric emergencies, among other components of adequate health care.

Medicine should also see to it that voluntary health insurance programs are tailored to the economic facts of life of the consumer-patient public.

In summarizing, Doctor Anderson stated that "The individual physician and his associates must clearly appreciate the existence of changing public attitudes toward medical and hospital care. Solutions of the vast problems posed by these changing attitudes can only be accomplished by direct involvement with other interested segments of society to achieve mutual education, mutual understanding of problems, and achievement of mutual goals, within the framework of social and economic reality."

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This is the season Allbee® with C is made for!

When a good old-fashioned winter proves too much for your modern-day patients, it's a comfort to know about Allbee with C. Consider its simple, rational, economical formula when patients need therapeutic amounts of B and C vitamins during the "flu" and u.r.i. season. **This is what Allbee with C is made of:** Thiamine mononitrate (B_1), 15 mg.; Riboflavin (B_2), 10 mg.; Pyridoxine HCl (B_6), 5 mg.; Nicotinamide, 50 mg.; Calcium pantothenate, 10 mg.; Ascorbic acid (vitamin C), 300 mg.

A. H. Robins, Co., Inc. Richmond 20, Va.


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for patients who cough like the dickens... Great Expectorants by A. H. Robins

Back in Dickens' day, about the only remedy they had for a bad cough was time—and an occasional sip of rock-and-rye. Nowadays however, when dealing with bronchitis, croup, and URI, you can prescribe with "great expectations" of success by choosing one of Robins' great expectorants.

Although each Robins' antitussive is formulated for a cougher's special need, all contain glyceryl guaiacolate, a superior expectorant that produces significant increases in respiratory tract fluid (RTF) secretions.* By stimulating the natural production of RTF, glyceryl guaiacolate makes fewer coughs more productive so that the cough itself removes the very irritants that cause it.

After millions of prescriptions, no significant side effects have ever been reported from glyceryl guaiacolate. And acceptance of these elegant and highly palatable formulations by patients has always been outstanding. Whenever you treat patients who are coughing "like the dickens," give them relief with one of Robins' great expectorants.

A. H. Robins Company, Inc. Richmond, Va. 23220

ROBITUSSIN®

antitussive / demulcent / expectorant

Each 5 cc. (1 tsp.) contains:

Glyceryl guaiacolate	100 mg.

Alcohol 3.5 per cent

ROBITUSSIN® A-C (exempt narcotic)

Robitussin with antihistamine and codeine

Each 5 cc. (1 tsp.) contains:

Glyceryl guaiacolate	100 mg.
Pheniramine maleate	7.5 mg.
Codeine phosphate	10.0 mg.

(Warning: may be habit forming)

Alcohol 3.5 per cent

Robitussin is indicated in coughs associated with head and chest colds, bronchitis, laryngitis, tracheitis, pharyngitis, pertussis, "flu," "grippe," measles, chronic paranasal sinusitis, pulmonary tuberculosis, or smoking. Robitussin A-C is especially indicated for allergic, harsh or unresponsive coughs.

dosage: ADULTS—1 tsp. every 3 to 4 hours. CHILDREN—½ tsp. every 3 to 4 hours.

side effects: No serious side effects from glyceryl guaiacolate have ever been reported. Nausea, G-I upset, and drowsiness may be encountered rarely with Robitussin A-C.

precautions: There are no contraindications for Robitussin. Robitussin A-C is contraindicated in patients hypersensitive to antihistamines or codeine.

DIMETANE® EXPECTORANT

antihistaminic / antitussive

Each 5 cc. (1 tsp.) contains:

Dimetane® (brompheniramine maleate)	2 mg.
Phenylephrine hydrochloride	5 mg.
Phenylpropanolamine hydrochloride	5 mg.
Glyceryl guaiacolate	100 mg.

Alcohol 3.5 per cent in a palatable, aromatic base.

DIMETANE® EXPECTORANT-DC

(exempt narcotic)

antihistaminic / antitussive / suppressant

Codeine phosphate	10 mg.

(Warning: may be habit forming)

Dimetane® (brompheniramine maleate)	2 mg.
Phenylephrine hydrochloride	5 mg.
Phenylpropanolamine hydrochloride	5 mg.
Glyceryl guaiacolate	100 mg.

Alcohol 3.5 per cent in a palatable, aromatic base.

Indicated for relief of cough and allergic states in which an expectorant action is useful. Dimetane Expectorant-DC is indicated when the cough suppressant action of codeine is desired.

dosage: ADULTS—1 to 2 tsp. q.i.d., as necessary. CHILDREN—½ to 1 tsp., t.i.d. or q.i.d.

side effects: Overdosage may result in mild drowsiness or excitement, but within the therapeutic range neither is likely.

Precautions: Administer with caution to patients with cardiac or peripheral vascular diseases and hypertension.

contraindications: Hypersensitivity to antihistamines or codeine. Not recommended for use during pregnancy.

references:* Boyd, E. M., and Ronan, A. K.: Am. J. Physiol., 135:383, 1942.

PUBLIC HEALTH PAGE

Encephalitis Epidemic in Danville, Kentucky*

RUSSELL E. TEAGUE, M.D., M.P.H.

Commissioner of Health Commonwealth of Kentucky

ON JULY 12, 1964, a somewhat unusual train of events was set in motion by the reporting of a case of meningitis at Kentucky State Hospital, four miles outside Danville, Kentucky. Culture of this patient's cerebrospinal fluid revealed this to be Hemophilus influenzae although Meningococcal Meningitis was the tentative diagnosis. Subsequently, on August 5, the first of 25 patients who were hospitalized, at the time of this communication, was admitted to Ephraim McDowell Hospital in Danville. CSF smears on 10 of the first 15 cases revealed a Gram negative rod, in varying numbers, identical to that found in the initial case. This organism could be cultured in only one case, that of a severely ill four-year-old boy. This organism was not seen on CSF smears or cultures in the last 10 cases. CSF findings were compared with those of patients in the Houston, Texas area where a confirmed outbreak of St. Louis Encephalitis has occurred and they are similiar. Cell counts range from 26 to 600 generally with a predominance of polymorphonuclear leukocytes, protein has usually been slightly elevated and sugar has been about normal.

Symptomatology has been similiar in all of the hospitalized cases as well as a large number of patients seen by local physicians but not requiring hospitalizing. Predominant symptoms have almost always been severe persistent headache of more than 24 hours duration, fever ranging from 101-105°, and anorexia with and without nausea and vomiting. Some have had nuchal rigidity, ocular palsies, incoherence, voice changes, and one patient has convulsed. The patients' ages range from 4 to 89 years. One death has occurred in an 89-year-old woman. Autopsy was performed but there were no gross findings of either encephalitis or meningitis. The immediate cause of death has been attributed to arteriosclerotic heart disease and pneumonia. Microscopic studies of central nervous tissue are not complete.

From the earlier cases both acute and convalescent blood specimens have been taken for serology complement-fixation studies at the State Health Department Laboratory and the Communicable Disease Center, Atlanta, Georgia.

To date blood serum from a 42-year-old patient has shown an antibody titer of 1:8 to St. Louis type encephalitis antigen after 10 days of illness. An eight-year-old patient, with no titer demonstrable on serum from the acute phase of illness, has shown 1:32 titer to St. Louis encephalitis on convalescent phase serum collected 20 days after onset of illness.

Epidemiologic investigation, under the direction of the field investigator, J. Clifford Todd, is continuing. Acute and convalescent blood specimens from hospitalized patients and retrospectively from earlier suspected cases not hospitalized, are being obtained from complement-fixing antibodies, neutralizing antibodies, and hemagglutination inhibitors. Blood from various birds, chickens, and horses has been obtained to determine the extent of infections in these animals. Mosquitoes are being trapped for virus isolation.

The city of Danville was sprayed by plane on September 4 because of complaints of residents about the numbers of mosquitoes. This was done prior to the mosquito-borne disease being suspected. The State Department of Agriculture has moved into Danville with all available equipment for mosquito eradication. Fogging procedures are being carried out to kill adult mosquitoes while wet spraying is being done in all stagnant water areas to kill the mosquito larvae.

**This article was prepared by Logan Ray Campbell, M.D., Health Officer, Boyle County Health Department, Danville, Ky.*

Outwardly calm...but what goes on inside?

Appearances on the outside do not necessarily suggest what goes on inside. This is particularly true of the ulcer patient, who may appear jolly and unruffled to his neighbors, but presents to you the classic symptoms: organic and functional disorders of the G.I. tract, associated with anxiety and tension.

Consider, when you see him next, the value of PATHILON® SEQUELS® with Phenobarbital, which provides sustained anticholinergic protection from spasm and pain in the target areas, as well as sustained phenobarbital action against triggering anxiety. The controlled release of the active ingredients in the SEQUELS® formulation means protective medication day and night.

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Side Effects (due to tridihexethyl chloride): dry mouth, blurring of vision, constipation.

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Pathilon® Sequels® with Phenobarbital Sustained Release Capsules

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Note:
Adams,* whose 50 patients included 20 with ENT infections, stated that Signemycin "was particularly valuable in infections that did not respond to other antimicrobial agents, and in patients to whom penicillin could not be given." All his cases responded within five days; in most patients, all signs of infection disappeared in three days.

*Adams, J.: J. Tenn. Med. Ass. 50:446, Nov., 1957.

Condition	No. of Patients	No. Cured with Signemycin
Otitis media	90	86
Pharyngitis and laryngitis	162	148
Sinusitis	68	55
Tonsillitis and peritonsillitis	163	153
Various	24	23
Totals	507	465 (91.7%)

consistently effective...often when others fail

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tetracycline HCl, 167 mg.; oleandomycin as triacetyloleandomycin, 83 mg. capsules (250 mg.)

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Of 1,088 patients with confirmed skin and soft-tissue infections... 1,036 or 95.2% were treated successfully with Signemycin®

Note:
Morador et al.* obtained *excellent results in the treatment of 185 out of 191 soft-tissue infections,* all due to staphylococci. They state: "In the most serious infections occurring in patients with impaired resistance (mainly diabetics) we have had very good results in the control of the infectious condition." In these studies, incision and drainage were employed where indicated.

*Morador, J. L. et al.: Antibiot. Ann. 1959-1960:716.

Condition	No. of Patients	No. Cured with Signemycin
Abscesses, various	35	34
Abscess, gluteal or perianal	54	52
Burns, infected	331	307
Carbuncles and furuncles	125	122
Cellulitis	104	102
Lacerations and wounds, infected	142	128
Ulcers, infected	107	106
Various superficial infections	190	185
Totals	1,088	1,036 (95.2%)

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tetracycline HCl, 167 mg.; oleandomycin as triacetyloleandomycin, 83 mg. capsules (250 mg.)

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Pheochromocytoma: Recent Experiences With Two Cases

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Pheochromocytoma appears to be an increasing cause of curable hypertension. Elevated V.M.A. and urinary catechol amines are required before exploration can be soundly advised. Patient survival requires constant early postoperative vigilance.

THOUGH the etiology of hypertension frequently is obscure, the complications are vivid. Since some forms of hypertension may be curable, an awareness of remediable lesions is necessary. The clinical history may arouse suspicion but an aortogram is required to disclose renal stenosis, the serum potassium determination to reveal an aldosterone secreting tumor, and the tests for vanillyl mandelic acid or urine catechol amines to confirm the presence of pheochromocytoma. Presently, it appears that the growing incidence of pheochromocytoma is a reflection of improved diagnosis, for more cases have been reported during the last ten years than in all previous decades. The incidence is considered to range from 0.35 percent to 0.45 percent of all hypertensives.[1] Two additional cases of pheochromocytoma are herewith reported to affirm that some measure of success can be achieved by correct diagnosis and surgical ablation.

The undiagnosed pheochromocytoma is a notorious harbinger of hypertensive sequelae. The devastating effects on the coronary circulation as well as cerebral sufficiency are well documented. The lethal dissecting aneurysm occupies a significant niche in the mortality charts. Sustained hypertension may cause sufficient renal damage to induce persistent post excision elevation of blood pressure. Unsuspected pheochromocytomas strikingly increase the incidence of operative deaths from unrelated surgical procedures. The mortality in children and pregnant females with an undetected pheochrocytoma is also forebodingly high[4]. Those features alone are reason enough for early disclosure and resection.

Apparently, hypertension induced by the pheochromocytoma develops from execssive liberation of nor-epinephrine and/or epinephrine into the systemic circulation. Epinephrine is produced only by the adrenal medulla whereas nor-epinephrine is manufactured by both the adrenal and sympathetic ganglia or nerve endings[3]. Usually, the release of those vasoactive agents is spasmodic and the response is experienced as attacks or crises. However, one of three patients exhibits sustained blood pressure elevation. Nor-epinephrine mediates its effect by potent vasoconstriction of the arteriolar circulation. Peripherally, it is sixty

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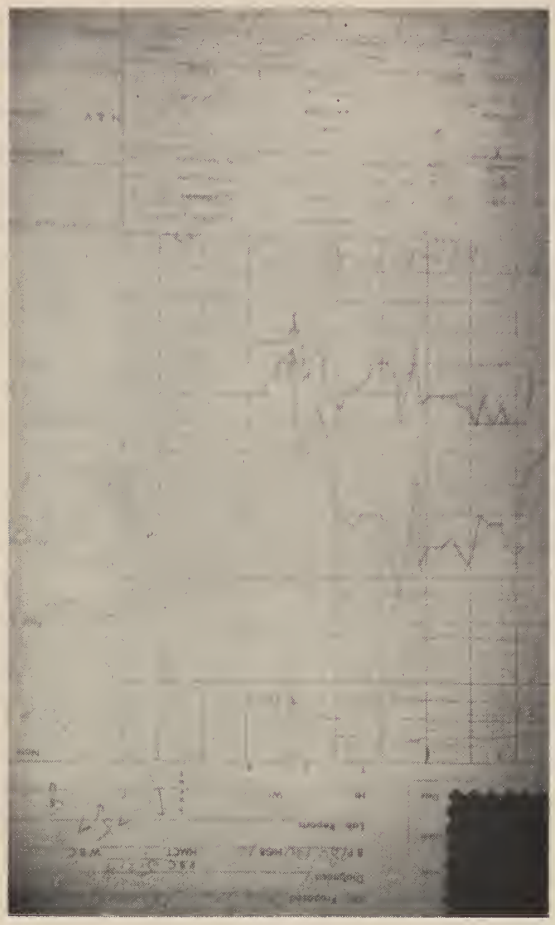

Figure 1 — Anesthesia chart on Case #1, H. C.: Explosive elevation of blood pressure during manipulation of the pheochromocytoma followed by sharp depression after excision.

times more active than epinephrine whose prime effect appears to be on cardiac output and glycogen metabolism. Dizziness, tremulousness, convulsions, and peripheral mottling indicate a chromaffin tumor elaborating principally non-pinephrine. Rise in blood sugar with glycosuria, elevated temperature and pulse rate, and hypermetabolism manifested by increased oxygen demand suggest a predominant release of epinephrine.

Case #1, H. C.—This fifty-nine year old white, male, lathe operator was well until eighteen months prior to admission when he began to experience headaches, palpitations, dizziness, and blurring of vision. He was brought to the emergency room of the Norton Memorial Infirmary with a left hemiparesis. At the time of the initial admission, his blood pressure was 240/110. He was febrile, sweaty, and confused. After three days of hospitalization, the hemiparesis cleared and he insisted on being discharged. He was subsequently followed in the office of one of us (JEB) for further evaluation of his hypertension. An intravenous phentolamine (Regitine®) test produced an abrupt fall in blood pressure from 190/100 to 60/0. With this provocative test, the patient was readmitted to the hospital. The urinary catechol amines were significantly elevated. X-rays failed to delineate the lesion.

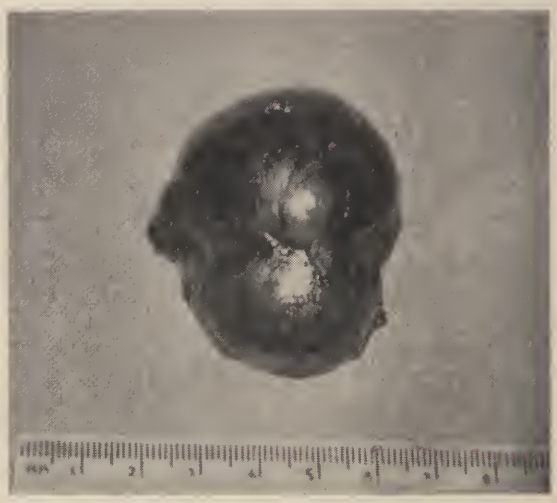

Figure 2 — A pheochromocytoma of the right adrenal gland weighing 50 grams removed from Case #1, H. C.

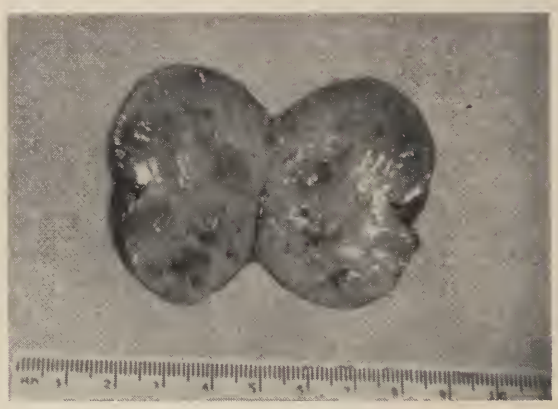

Figure 3 — Cross section of pheochromocytoma removed from Case #1, H. C.

The patient was explored through an upper abdominal transverse incision. A lemon sized, solid mass was discovered incorporating the upper pole of the right adrenal gland. During dissection, the blood pressure spiked to 300/40. Intravenous phentolamine dropped the blood pressure to safer operating levels. As soon as the tumor was excised, the blood pressure was unobtainable. Four ampules of 0.2 percent levarterenol solution in each 1000 cc. of 5% dextrose and water were required for ninety-six hours to maintain blood pressure at

Figure 4 — Histologic section from a representative area of the pheochromocytoma removed from Case #1, H. C.

a systolic level of 100 millimeters of mercury. On the fifth postoperative day, the levarterenol could be discontinued but when the patient was erect, the blood pressure could not be recorded. However, by the seventh postoperative day, the blood pressure was consistently 104/60 when he was upright.

A four-year follow-up revealed his blood pressure as stable between 140 to 150 over 90 mm.Hg. He has undergone two subsequent surgical procedures without event. There have been no additional hypertensive crises.

Case #2, L. H.—This fifty-one year old, obese, white, male, post office inspector began to notice episodic attacks of blood pressure elevation fourteen months prior to admission to the Norton Memorial Infirmary. During the crises, he complained of throbbing pain in the right side of the neck extending cephalad over the temple area. He described the attacks as loss of control and tremulousness. During the crises his blood pressure soared to 220 to 240 over 110 to 130 mm.Hg. Ordinarily, his blood pressure ranged from 140 to 160 over 85 to 95 mm.Hg. A workup by one of us (FAO) divulged elevation of two consecutive vanillyl mandelic acid tests, but two tests for urinary catechol amines were borderline. A retrograde aortogram intimated a tumor of the right adrenal gland.

Accordingly, he was explored through an upper transverse abdominal incision. The right adrenal was enlarged and cystic. The left adrenal was normal to palpation and inspection. No other lesions were uncovered along the sympathetic chain or near the aortic bifurcation. The right colon was reflected and the right adrenal mobilized. Concomitant with the dissection, the blood pressure rose to 220/110. Upon ligation of the adrenal veins, it rapidly fell to 80/40. He withstood the procedure well but required two ampules of 0.2 percent levarterenol solution in each 1000 cc. of 5% dextrose and water for the first twenty-four hours. After the first postoperative day, his blood pressure stabilized at 150/80. His course was not plagued with orthostatic hypotension. He was discharged on his eighth postoperative day.

Histological examination of the right adrenal gland disclosed cystic degeneration of a benign neoplasm of the medulla. Silver stains confirmed a pheochromocytoma.

An eighteen month follow-up reveals no further attacks of hypertension. The blood pressure apparently has leveled off at 140 to 160 over 80 to 90.

Discussion

Certain suggestions and clues might be helpful in uncovering a functioning chromaffin tumor. Pheochromocytoma is rare but probably less so than was formerly presumed. Any evaluation of hypertensive cardiovascular disease should exclude an adrenal tumor. Familial occurrence suggests a genetic mechanism[8]. Neurofibromatosis has been recorded in five to twenty percent of all pheochromocytomas[5]. Calcification in the area of the adrenal gland in the hypertensive patient suggests a pheochromocytoma. Palpable tumors occur in about fifteen percent of the cases[2]. The standardized phentolamine test is a satsfactory screening measure. The histamine test has little to recommend it. The vanillyl mandelic acid or the urinary catechol amines should be determined to be elevated before exploration can be soundly advised. However, the tests have little significance in intermittent hypertension if the urine collections are not made during the crises. Antihypertensive drugs should also be omitted prior to tests for pressor amines[6].

Unless the neoplasm is large, it is impossible to be certain of its exact location. The operator must be prepared for anatomical dissection of either adrenal, sympathetic chain, or aortic bifurcation. The upper abdominal transverse incision has been advocated by many. Scott, however, is a proponent of the upper mid line incision with extension into the appropriate pleural cavity[7]. There seems to be little justification for the flank incision except in dealing with palpable tumors. Since multiplicity is encountered in approximately ten percent, all ectopic areas must be examined. Failure of blood pressure to drop following resection of a

phcochromocytoma sugggest residual chromaffin tumor. Malignancy ocurs in about ten percent and the resectability rate is low due to invasion of adjacent vessels. Also, malignancy portends sustained hypertension with rapid deterioration of the cardiorenal system.

During the operative dissection, success is often dependent on a reliable venous cut down for administration of phentolamine or levarterenol. One individual in the operating room is designated to record the blood pressure every thirty scconds during and immediately after excision of the tumor. Until the adrenal veins are clamped, there is continuous elaboration of vasoactive substances from mechanical manipulation of the gland. This may cause explosive elevation of the blood prcssure which must be diligently regulated by phentolamine. Arrhythmias are also common. A cardiac monitor is of some merit here. Early post excision levarterenol requirements must be carefully titrated against the hypotension. The levarterenol demands are, no doubt, a reflection of the amount of epinephrine-like substance previously liberated by the tumor and the labile vasomotor stability of the arteriolar circulation. Postoperatively, the patient is rapidly weaned from levarternol because of the hazards of mucosal necrosis in the gastrointestinal tract.

Follow-up discloses that in almost all reported cases the hypertensive crises have been eliminated. Occasionally, a patient will be encountered who has renal disease superimposed on a preochromocytoma. The most that can be hoped for under those circumstances is freedom from attacks. Obviously, there are few occasions when such vigorous, coordinated attention is demanded of the internist, surgeon, and anesthesiologist. Failure to observe the most minute details in the management of the patient who has become accustomed to high circulating levels of epinephrine-like substances may well lead to death. The results are usually gratifying and this seems ample reward for the time and anxiety required for evaluation, surgical excision, careful anesthcsia, and postoperative care.

Summary and Conclusions

Thc complications of hypertension demand that a pheochromocytoma be excluded in each hypertensive patient. The diagnosis is suggested by a clinical history of erratic or sustained hypertension, peripheral vasoconstriction, hypermetabolism, and glycosuria. Elevated VMA and urinary catechol amines are required for confirmation. Multiple tumors are known to exist in approximately ten percent. Ectopic pheochromocytomas have been reported in eight to ten percent. Malignancy has also been observed in about eight percent of the cases. Attention to minute details, pre and post excision, is demanded for patient survival. Two patients who have undergone successful resection of pheochromocytoma are reported.

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Liver Biopsy: A 10 Year Survey at Louisville General Hospital

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Experience with 389 liver biopsies confirms the reported low mortality. Diagnostic accuracy has shown a progressive increase. In the past two years, this procedure has been helpful in diagnosis in over 80% of cases.

THE first large series of percutaneous liver biopsies was reported by Iverson and Roholm in 1939.[1] Since that time, the procedure has been performed increasingly for diagnostic purposes and now enjoys wide acceptance. Recent changes in needle design have simplified the biopsy technic. In the last 10 years at The Louisville General Hospital, 3 different biopsy needles have been in use. In accord with the trend toward increasing frequency of liver biopsy, we have come to rely on this diagnostic aid in a number of clinical situations. It was felt that review of our experience during this 10 year period in regard to diagnostic accuracy, number of biopsies performed and safety of the procedure would be of interest.

Materials and Methods

Charts were reviewed from May 1954 to May 1963 with special attention to admission clinical diagnoses, histopathologic reports on liver biopsy, subsequent clinical course including autopsy reports where available and type of biopsy needle. Histologic sections were reviewed in cases of special interest and where it appeared that the interpretation might have changed in the light of further clinical evidence. Since July 1961, all liver biopsies have been reviewed in evaluation of patients by the senior author. Biopsy specimens were classified according to their relationship to the provisional clinical diagnosis. These were categorized as follows:

I. Helpful in diagnosis
   A. Confirmed the clinical diagnosis
   B. Corrected the clinical diagnosis

II. Of no help in diagnosis
   A. Noncontributory
   B. Inadequate specimen

The biopsy procedure is designed to secure tissue which is adequate for histopathologic study; failure to achieve an adequate sample precludes clinicopathological correlation and thereby adds nothing. In focal liver disease, the findings may be misleading through failure to sample the morbid process. Since many feel that fatty metamorphosis is a precursor of nutritional cirrhosis,[2] for classification purposes fatty metamorphosis of the liver was included in the clinical constellation of portal cirrhosis.

Not all clinical records stated the type of biopsy needle used. However, only the Vim-Silverman needle was used from 1954 until 1957. In 1957 the Franseen needle became available at our hospital and was the type most widely used from 1957-1961. In July, 1961 the Menghini needle became available and since that time has been the preferred instrument.

For more detailed discussion of the actual technic of liver biopsy, indications, and needle types chapter no. 6 in Schiff's *Diseases of the Liver* is highly recommended.[3]

Needle Types

The Vim-Silverman needle[4] is the instrument which has had the most extensive use in liver biopsy. This is a split needle for punch biopsy with an outer cannula. The split needle is introduced into the liver and the outer cannula is advanced over the needle thus separating the biopsy core from the rest of the liver. This needle delivers a specimen of 1 mm. diameter. A moderate amount of manual dexterity is required by the operator, and the patient is required to hold his breath for about 30 seconds during the procedure.

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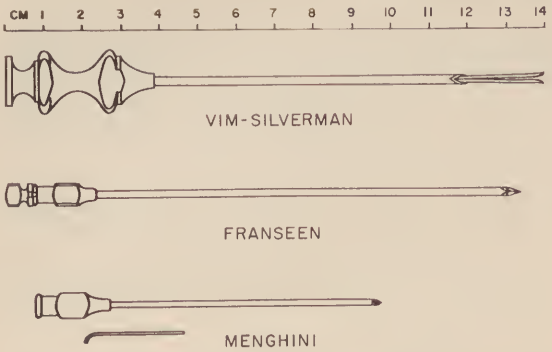

Figure 1. The three types of needles used in this study are shown. Note the relative sizes of the three.

The Franseen needle is an aspiration type biopsy instrument with its own trochar and cutting edges on the needle tip.[5] After the hollow needle is advanced into the liver, a saline filled syringe is attached and gentle aspiration is applied while the needle is withdrawn. The time required for breath-holding is only about 15 seconds. It is the general procedure to make only one attempt to obtain liver tissue with the Vim-Silverman or Franseen needles. Occasionally, if no liver tissue is obtained, a second attempt is made at that time.

The Menghini aspiration biopsy needle is the shortest of the three and delivers a specimen 1.2 mm. in diameter.[6] Several bores are available but the 1.2 mm. is used most often. Since the needle is introduced with an aspirating syringe attached, breath-holding time is only about five seconds. Indeed, Professor Menghini calls this procedure the "one-second biopsy," but we usually perform the maneuver more leisurely than this.

Although the Menghini needle provides a relatively short specimen, multiple biopsies can be obtained with greater ease and safety. Our present routine involves two consecutive attempts to aspirate tissue at the time of the initial biopsy. If this provides no tissue, two or three additional aspirations may be carried out safely.

Since all three needle types are satisfactory, the main reason for preference of the Menghini is that it requires the least number of manipulations to obtain an adequate specimen, and since it is the smallest of the three, it should offer some theoretic advantage as far as post-biopsy hemorrhage is concerned. Hence, it seems best adapted for teaching the technic of liver biopsy.

Morbidity and Mortality

In this series, there was only one death which might be attributable to liver biopsy. Biopsy was performed in 1954 with the Vim-Silverman needle in a debilitated man who died 18 hours later without signs of peritonitis or drop in hemoglobin concentration. Autopsy was refused, so that exact cause of death could not be determined. However, attributing this one death to liver biopsy in 389 procedures gives a mortality rate of 0.26%. Liver biopsy, thus, has been a relatively safe procedure in our hands using the standard precautions.[3] Our apparent mortality rate was higher than that of Terry[7] whose compilation of 10,600 reported cases revealed a mortality of 0.12%.

In a study of this type, morbidity is somewhat difficult to quantify. The most common complaint was mild pain at the biopsy site. This was present in about 15% of the overall series; it was transient and usually required only mild analgesics. No episodes of bile peritonitis or significant pneumothorax were produced. We have the impression that the Menghini needle produces the least amount of post biopsy pain. In fact, a few patients with chronic liver disease who have had biopsies with all three needles have expressed a definite preference for this needle.

Aid in Diagnosis

As outlined above, the periods in Fig. 2 are divided according to the needle type in predominant use. The percentage of inadequate specimens showed a progressive decrease during each period. It should be pointed out that from 1954 to 1957 biopsies were performed by internists or by house officers under their supervision. Since July 1957 almost all biopsies have been performed by or under the supervision of the staff of the gastroenterology section. Since July 1961 approximately half of the liver biopsies have been performed by or directly under the supervision of the senior author.

The percentage of positive aid in diagnosis for the three periods has been 63, 75, and 85 per cent respectively. No doubt, this increase is in part due to the decreasing number of inadequate specimens. Also affecting the number of confirmed diagnoses was the fact that, with the increasing ease and safety of biopsy, serial biopsies were performed more frequently in order to follow more completely the course

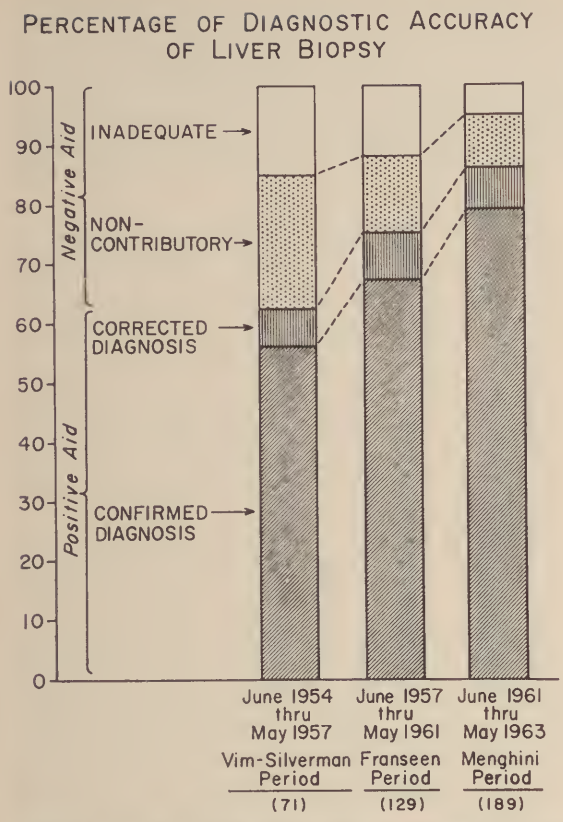

Figure 2. This figure shows the percentage of liver biopsies assigned to each category. Note that the number of inadequate specimens gets progressively smaller and the per cent of liver biopsies which corrected the clinical diagnosis remains at about 8 per cent. The number of biopsies in each period is in parentheses.

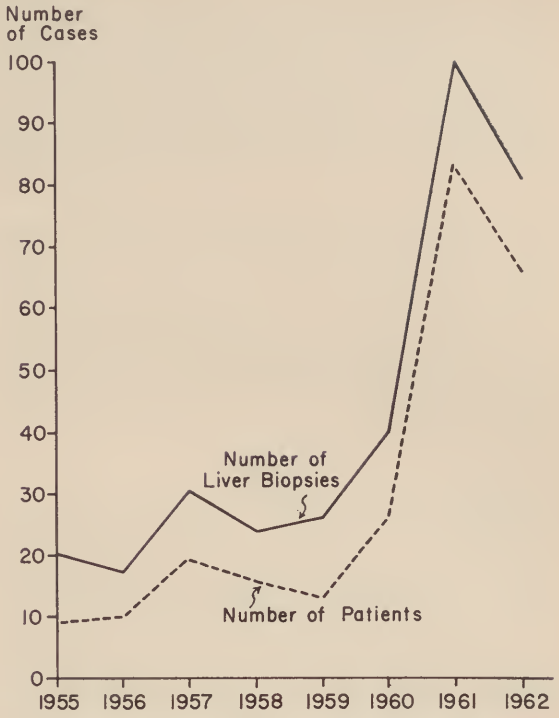

Figure 3. This figure shows the number of liver biopsies and the number of patients per year. The portions of 1954 and 1963 which were included in this survey were not included in order to show only complete years.

of chronic liver disease. Indeed, one relatively young patient with alcoholic cirrhosis and pancreatitis had a total of nine liver biopsies.

Figure 3 shows the increase in number of biopsies performed per year. The part years of 1954 and 1963 were not included in order to show only complete years. The slight drop in number of biopsies performed in 1962 may be due to the fact that there was no senior resident assigned exclusively to the gastroenterology service for the last six months; hence, there was one less person available to perform or teach this technic.

Biopsies which result in revision of clinical diagnosis are of greatest diagnostic value when they occur. It is interesting that these remain about 8 per cent of the total during each of the three periods. Diagnoses in this category include amyloidosis, sarcoidosis, histoplasmosis, tuberculosis and primary and metastatic neoplasms of the liver. In regard to metastatic cancer, Conn and Yerger[8] point out that among all livers containing metastatic cancer 50 per cent will show cancer on one random needle biopsy specimen. By the time there are clinical signs of cancer of the liver, a single needle biopsy will yield malignant tissue approximately 90 per cent of the time. Consequently, they advise liver biopsy in all cases of carcinoma in the thorax about to undergo resection for cure to help rule out those with carcinoma already metastatic to the liver.

Summary and Conclusions

Percutaneous liver biopsy at The Louisville General Hospital for the last 10 years has been reviewed. There was one death in 389 biopsies, a mortality rate of 0.26 per cent. When biopsy was performed by various groups on the medical service, the mortality was low but positive aid in diagnosis was approximately 60 per cent. When biopsy was performed with the Menghini needle under supervision of one group, the diagnostic accuracy exceeded 80 per cent. Because of the safety and accuracy of the procedure, we have come to rely increasingly on liver biopsy in evaluating patients with liver disease.

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Management of the Occiput Posterior*

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A previously described method of one finger rotation of the occiput posterior for delivery was employed 92 times in 1000 consecutive deliveries. After rotation, 52 per cent of them delivered spontaneously.

MEDICAL literature over the years has had a great number of articles dealing with problems in management of the occiput posterior in obstetrics. This attests that a perfect management has not yet been found. An obstetrician may adopt a method, or methods, which are satisfactory to him in his hands, but the same method might not appeal to another. Skill in this field is attained only by repeated trial, and a realization that all rotations cannot be accomplished with equal ease.

Certain principles have evolved in dealing with the occiput posterior which I believe are being taught to present day medical students. These principles include:

1. If forceps rotation is to be done, a forceps should be selected which has very little pelvic curve.

2. The principles of Bill[1] are an improvement over the original Scanzoni.

3. Manual rotation, when it can be accomplished, in the hands of most operators is safer for the mother and baby than is forceps rotation.

4. The vacuum cup extractor appears to have some potential as a rotator. I have had no experience with this instrument.

An appreciable percentage of heads engage in the occiput posterior position, especially in the anthropoid type of pelvis. No very reliable figures are available as to what actual percentage begin as posteriors, since the majority, in time, tend to rotate spontaneously. The patient, conservative obstetrician is therefore gratified when the forces of uterine contractions plus an eventually dilated cervix, plus the pelvic plane factors, result in rotation. The time required, however, may be exhausting to the mother, inimical to the welfare of the baby, and exasperating to the obstetrician.

An effective, non traumatizing assistance to the natural tendency toward rotating in the first stage of labor would be ideal. It can only be done when the cervix is fully dilated or nearing full dilatation.

As a resident in obstetrics I was taught to do manual rotations whenever possible in the interest of safety. I was never too skillful with the conventional methods such as the Danforth[2] method of grasping the head as one would a baseball, or other procedures. Often the head was displaced upward to an undesirable station for forceps application. I conceived of the idea of using two fingers as a fulcrum to direct the occiput anterior during a contraction. I met with only indifferent success in my efforts, and gave up the idea.

The Maneuver

In September 1947, at the annual meeting of the Kentucky State Medical Association, the late Dr. C. J. McDevitt, a former president of this Society, presented a paper in which he described one finger rotation of the occiput posterior.[3] I shall read his description of the method as he presented it:

"The maneuver which I have used for the past four years is this: With the patient well sedated but not beyond the cooperative state, the cervix completely dilated and effaced, the head in the pelvis and the bladder empty, she is given 4 or 5 deep breaths of nitrous oxide at the beginning of a contraction and then told to bear down. The anterior suture of the three sutures that make up the "Y" of the posterior fontanelle is then grasped by the index finger and force exerted toward anterior rotation without upward pressure. It is easier to use the right index finger in the left posterior position and the left index finger in the right posterior position." Dr. McDavitt stated that after rotation the primagravidas were usually delivered

* *Presented at the Kentucky Obstetrical and Gynecological Society meeting at Lexington, Kentucky, May 9, 1963.*

by forceps, while the multigravidas were usually allowed to deliver spontaneously.

This concise description of a rather simple procedure was confidence inspiring and I was encouraged to pursue the method with renewed interest. The only thing that I have added to the maneuver is to use the free hand to exert pressure on the diagonally opposite pole of the uterus during the contraction. In other words, with an LOP position the right index finger is employed on the anterior angle of the lambdoidal suture, exerting pressure to effect rotation, while the left hand is used at the right cornua, or right upper extent of the fundus, to exert pressure downward. This, I have found, adds much to the success of the maneuver. Counter pressure from the diagonally opposite pole appears to give a spiral motion to the fetal ovoid.

Poor flexion of the fetal head is one of the factors in improper rotation, especially in the occiput transverse position. It is often found that as progress is made with successive contractions, the finger or two fingers, may actually be hooked around the occiput so that rotational and downward pressure causes a dramatic increase in flexion of the head, with now readily completed rotation.

In order to evaluate the frequency and adequacy of this method of dealing with the posterior occiput, I decided to determine how it fit into the total experience of 1000 consecutive deliveries. About a year and a half ago I took the past 1000 consecutive deliveries from private practice to arrive at this profile. Figure 1 shows the positions, or general management problems in the group studied.

Occiput Anterior	
Spontaneous	487
Forceps	314
Occiput Posterior	133
Brow (delivered as brow ant.)	4
Military	1
Breech	31
Caesarean Sections	30
Total	1000

Figure 1. Profile of 1000 consecutive deliveries. Percentages may be readily visualized by placing a decimal in front of the ones digit.

Figure 2 gives a break down of the occiput posteriors and the manner in which they were handled.

Occiput Posterior (13.3 percent of 1000 deliveries)	133	
Method of delivery	number	percent of posteriors encountered
Spontaneous as Posterior	2	1.5
Forceps as Posterior	2	1.5
Manual rotation 1 finger	92	69.1
(Spontaneous Del.)	48	
(Forceps Del.)	44	
Manual rotation (conventional & forceps)	6	4.5
Bill	17	12.7
Scanzoni	1	0.7
Manual rotation 1 finger to transverse & forceps (Key-in-lock)	12	9.0
Kielland forceps	1	0.7

Figure 2. Management of 133 occiputs posterior positions occurring in 1000 consecutive deliveries.

Discussion

A certain amount of patience is necessary to accomplish results. While many rotations may be executed during only one or two contractions, it may be necessary to persist for as many as five or six contractions. The prevention of maternal trauma by this method is well worth the extra time required. The undesirable feature of displacing the head upward by other methods of manual rotations is not encountered with this maneuver.

One gravida IV was taken to the delivery room prematurely. The cervix was found to be six centimeters dilated, with a right occiput posterior. Rotation was done, but the cervix was rather rigid so the patient was returned to her bed. The position remained ROA and in one hour she was completely dilated, and delivered spontaneously. This case is cited to bring out one point. No trauma was done to the patient by this method of rotation. Neither had I committed myself to immediate delivery.

In a number of patients rotation was carried out at eight centimeters dilatation, and in multiparas particularly it was found that rotation of the head was all that was needed for descent and delivery with the next few contractions. My practice is to allow spontaneous delivery if rotation is done before complete dilatation, then I am sure that further dilatation of the cervix is accomplished by natural forces, and not lacerated by forceps.

This is not an effective method for rotation of a transverse arrest. Poor flexion of the head appears to be responsible for this situation. By the same token, some poorly flexed heads may not be rotated beyond the transverse by finger rotation. This accounts for the 12 patients in

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Preleukemia: An Unusual Case of Nine Years Duration*

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A case is described of persistent leukopenia of nearly nine years duration before changes diagnostic of acute myelogenous leukemia became manifest. The difficulty of distinguishing the preleukemic state from other hematologic disorders is emphasized.

PRELEUKEMIA refers to the disease state in which various hematologic abnormalities may exist prior to the occurrence of the diagnostic changes of leukemia.[1] The preleukemic state is therefore of necessity a diagnosis made in retrospect. Despite the fact that intensive investigation gives no evidence of the presence of leukemia until late in its course, it would seem logical to consider the earlier phase of hematologic abnormalities a part of the natural history of leukemia. Early hematologic changes may be quite non-specific and atypical. These consist of various combinations of anemia, leukopenia, neutropenia, and thrombocytopenia, with a normal or hyperactive bone marrow.[2] The diagnostic spectrum suggested by these findings includes hypersplenism, myeloid metaplasia, aplastic anemia, splenic neutropenia, splenic pancytopenia, leukemoid reaction, primary refractory anemia, and thrombocytopenic purpura.[3]

In all reported cases the preleukemic period has been characterized by evidence of deficiency in at least one aspect of hematopoiesis, and usually there has been some evidence of an abnormal hemorrhagic tendency fairly early in the course of the illness. The length of the preleukemic phase before the diagnosis of leukemia could be firmly established has ranged from a few weeks to thirty-nine months[4] and in one instance almost nine years.[5] The case discussed here presented initially as a leukopenia of unexplained etiology and ran a preleukemic course of almost nine years. The time interval from the definite diagnosis of myelogenous leukemia until death was only six months.

Case Report

E. C., a 46-year-old laborer, was admitted to the hospital on May 22, 1962 for investigation of an unexplained anemia which had caused exertional dyspnea and fatigue for approximately three months. He had previously been hospitalized for nine months in 1943 and 1944 for gun shot wounds of the leg incurred in North Africa. In May 1953 cough and chest pain led to a chest x-ray showing infiltration in the right apex and a right pleural effusion. On June 26, 1953 he was admitted to a state tuberculosis hospital where the diagnosis of moderately advanced tuberculosis was made and therapy with streptomycin and para-aminosalicylic acid was instituted.

On June 30, 1953 a complete blood count revealed a hemoglobin of 11 gm. per 100 ml., a white-cell count of 4,800 with an entirely normal differential, and a red-cell count of 3,520,000. On September 14, 1953 the patient was transferred to the Veterans Administration Hospital at which time a blood count revealed a hemoglobin of 12.4 mg. per 100 ml., a red-cell count of 4,900,000, and a white-cell count of 7,800 with a normal differential. The next blood count was obtained on October 19, 1953 and revealed a white-cell count of 2,300 with no other detectable abnormalities. The patient maintained a persistent leukopenia from this time until his death on January 10, 1963.

Numerous studies were done to elucidate the cause of the leukopenia. Anti-tuberculosis chemotherapy was discontinued on November 23, 1953 and not reinstituted during hospitalization which continued until May 21, 1954. Repeated blood counts during this period of

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hospitalization constantly showed a leukopenia of from 1,400 to 2,700 white cells with entirely normal differential counts and no abnormal cells. On November 9, 1953 a bone marrow examination was performed and showed no suggestion of abnormality. Culture of the marrow was negative for acid fast bacilli.

Studies during the remainder of hospitalization included repeated platelet counts, electrophoresis of serum proteins, serum iron and iron binding capacities, gastric analysis, x-rays of the gastro-intestinal tract, repeated reticulocyte counts, red cell fragility test, urobilinogen determinations, direct and indirect Coombs tests and coagulation tests. These were all normal. There was no response of the reticulocytes or white cells to rapid withdrawal of 500 ml. of blood. There had been marked improvement of the apical parenchymal abnormality and the pleural effusion had cleared when the patient was discharged from the hospital on May 21, 1954.

On March 20, 1957 a rather extensive laceration of the foot led to a brief period of hospitalization. At this time the hemoglobin was reported as 9.9 gm. per 100 ml., red-cell count 3,750,000, and white-cell count 2,150 with a normal differential. On February 2, 1958 a recurrence of fever and chest pain precipitated another hospitalization. Parenchymal abnormality in the right apex and a left pleural effusion were found at this time with a sputum culture positive for growth of acid-fast bacilli. On admission to the hospital the hemoglobin was 7.2 gm. per 100 ml., red-cell count 2,730,000, and white-cell count 1,150 again with an entirely normal differential. Bone marrow examination showed some increase in erythropoiesis and a maturation arrest of the myelocytic series at the band-cell level. The patient was given two transfusions of 500 ml. of whole blood each and transferred to the Veterans Administration Hospital where he remained until May 27, 1959. During this long period of hospitalization the white-cell count varied from 1,250 to 3,500. The differential count remained normal at all times and no abnormal cells could ever be found. Exhaustive studies were again performed without abnormal findings. Bone marrow examination on March 13, 1958 showed hyperplasia of the erythropoietic series and an increase in the number of mature eosinophils. The patient was discharged on March 27, 1959 and remained in reasonably good health until symptoms required the present hospital admission.

On admission to the Norton Memorial Infirmary on May 22, 1962 there were no abnormal physical findings aside from pallor of the skin and mucous membranes. There was no palpable lymphadenopathy and no organs could be felt within the abdomen. The initial blood count revealed a hemoglobin of 4.0 gm. per 100 ml. and white-cell count of 2,500 with a normal differential. Numerous hematologic studies were inconclusive. A bone marrow examination showed hyperplasia of both the erythrocytic and granulocytic series with a maturation arrest at the myelocytic stage. Since the patient had continued taking PAS and INH from the time of hospitalization in 1958 until this admission, it was felt one of these drugs might be the cause of the hematologic findings. He was transfused and advised to discontinue the drugs. The chest x-ray now showed only fibrocalcific changes in the apex.

Hospitalization was again required on July 17, 1962 because of the return of symptoms of anemia. The physical examination at this time again revealed only pallor without palpable lymph node or organ enlargement. The hemoglobin was 5.0 gm. per 100 ml. and white-cell count 8,675 with a large number of myelocytes and myeloblasts present in the peripheral blood. Bone marrow examination now showed almost total replacement with myeloid elements of the myeloblastic phase and was considered typical of acute myelogenous leukemia. Repeated hospitalizations were necessary for transfusions and regulation of chemotherapy from this time until the patient's death on January 10, 1963.

At autopsy the findings were those of a generalized hemorrhagic tendency with petechiae and ecchymoses over the entire body. There had been generalized bleeding from the gastrointestinal tract. The liver weighed 3,000 gms. and the spleen 1,000 gms. There was leukemic infiltration of the lungs, adrenal glands, pancreas, and spleen.

Discussion

This report describes the existence of a constant leukopenia in an adult for almost nine years before the occurrence of the diagnostic hematologic changes of acute myelogenous leukemia and emphasizes the prolonged period during which abnormal hematologic findings

may be present before the true nature of the disorder is revealed. The change from normal to abnormal in the peripheral blood occurred sometime during a one-month period and persisted throughout the course of the illness. Bone marrow examination following demonstration of this abnormality was normal in all respects. Bone marrow examination will usually differentiate the leukemic process from other disease states but on occasion atypical clinical and laboratory manifestations may precede recognizable leukemia by several years.[1] It must be emphasized that during this state of preleukemia all attempts at diagnosis failed to establish the true nature of the disease. This situation differs from that atypical variety of acute leukemia wherein symptoms may persist in a low-grade or smoldering fashion for a period of months or years before death occurs from another cause or from a more typical acute phase of the leukemia.[6] Here the diagnosis can be made by careful evaluation of the marrow at the time the patient is initially evaluated.

In cases of subacute leukemia very careful studies may not provide a clear-cut diagnosis until a near-terminal state has been reached, although the clinical course, signs, and symptoms may be very suggestive of leukemia.[7] Even histologic examination of the spleen may fail to predict the subsequent development of leukemia in patients with pancytopenia and hyperactive marrow.[2] The preleukemic phase has not been reported to precede lymphoblastic leukemia and practically all cases have subsequently been classified as myeloblastic or monocytic.[4]

As in other cases, many diverse disease processes were considered while trying to establish the true diagnosis during the preleukemic state in this patient. When anemia has preceded other hematologic or clinical evidence of leukemia, it has been suggested that some dyshematopoietic agent was responsible for both conditions.[8] Drug toxicity seemed a reasonable explanation late in the course of this patient's illness. Aplastic anemia[9, 10] and myeloid metaplasia[11] have been particularly difficult to differentiate from the leukemic state. The initial marrow abnormality reported in this case seemed quite in keeping with the histologic sequence of events seen during suppression of the marrow or the acute toxic neutropenia produced by drugs.

Because the diagnosis of acute leukemia still carries a very poor prognosis and is thought of as a rapidly and uniformly fatal disease, methods have been sought to prove or exclude this diagnosis. A blast-cell count in the marrow greater than six per-cent has been said to constitute strong evidence for the diagnosis of leukemia.[12] Application of this criterion would not have helped establish the subsequent diagnosis in the case reported here. In the preleukemic phase it has not been possible to establish the subsequent diagnosis in any manner. Palpable enlargement of lymph nodes, liver, and spleen has been delayed until the true leukemic phase has been reached. Previously reported marrow changes have followed a general pattern of hypoplasia with maturation arrest to hyperplasia with maturation arrest of the granulocytic series to an overwhelming of the marrow with immature cells.[1]

The terminal period has been brief when compared with the preleukemic period and therapy has been generally disappointing. Though the natural history of acute leukemic in adults may differ significantly from the commonly accepted picture[13] this case is unusual in the extreme length of the preleukemic phase. Despite the present lack of a uniformly successful therapeutic agent, prolonged remission and survival in acute leukemia is possible,[14] and it would therefore seem desirable to establish the diagnosis as early as possible. Awareness of the possible existence of a prolonged preleukemic phase would then stimulate more accurate diagnosis and the search for more effective therapy.

Summary

A case of acute leukemia in an adult is reported in which distinct hematologic abnormality persisted for almost nine years before the diagnosis of leukemia could be made. The initial abnormality was an unexplained leukopenia. Exhaustive study could not elicit the cause of the leukopenia or reveal the true identity of the disease. Moderate pancytopenia developed following the leukopenia and subsequently typical changes of acute myeloblastic leukemia occurred late in the illness. Despite all attempts during this exceptionally long period the diagnosis remained obscure until the terminal phase. Further studies of patients during the early phase of hematologic abnormality should add to our knowledge of the leukemic process.

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Selective Gastric Vagotomy*

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Selective gastric vagotomy is a safe effective method for ablating the cephalic phase of gastric secretion. The rationale, anatomy, operative procedure and early superior results are discussed.

SELECTIVE vagotomy is the operative procedure in which complete gastric vagotomy is accomplished, at the same time preserving the vagal innervation to the liver, biliary tract, pancreas, small bowel and one-half the colon. Because of the increasing awareness of the symptom complex described as the post-vagotomy syndrome, this procedure has been proposed. It is the purpose of this paper to discuss the rationale, operative approach and the results of this procedure.

Selective gastric vagotomy was first proposed and performed in the late 1940s by Richard Jackson, M.D.,[1] now in practice in Danville, Kentucky. However, in that era of enthusiasm for extensive resection, selective vagotomy was not fully evaluated and, in fact, total vagotomy was not accepted by most centers throughout the country. However, because of increasing awareness and the greater understanding of gastric physiology, it has recently achieved a new interest and enthusiasm. Burge, in England,[2] Griffith and Harkins,[3] Kraft and Fry,[4] in this country, have re-evaluated and renewed the interest in this procedure in the hope of decreasing post-vagotomy symptoms.

Post-Vagotomy Symptoms

Post-vagotomy symptoms are vague and ill defined and not unlike those described as the Dumping Syndrome.

The symptoms are vague abdominal discomfort, recurrent episodes of abdominal distention and bloating, with intermittent episodes of borborygmi and are present in 20 to 30% of post-vagotomy patients carefully evaluated. The last and most troublesome symptom is post-vagotomy diarrhea, which varies in severity from one to two watery bowel movements per day, to as many as 15 per day. It is generally mild and does not require much care, particularly in those who had severe ulcer symptoms before surgery and accept these symptoms as minor in comparison. The diarrhea typically occurs in intermittent episodes for a few days each month and rapidly subsides. However, occasionally this is severe and permanently disabling.

Many have estimated this complication to be present in from 18 to 30% of patients following total vagotomy, with severe symptoms in 5%. Some have attributed this to hypo-acidity with secondary bacterial contamination, but careful investigative studies have not substantiated this thesis. Others have thought that gastric stasis with decomposition of food explained the entity, but again studies have refuted this and these patients generally have adequate emptying procedures by all the usual criteria.

What is the cause of the other post-vagotomy symptoms? Biliary stasis has been proposed, as it is known that gastric stasis occurs after para-sympathetic de-innervation and the analogy of biliary stasis has been proposed. Johnson and Boyden,[5] after previously revealing that the gall bladder was primarily under hormonal control, demonstrated the fasting volume of the gall bladder increased considerably, approximately doubling in size following vagotomy, as well as demonstrating an increase in the size of the common bile duct. Furthermore, the contractility of the gall bladder is very sluggish and slow to respond following vagotomy. Is it not possible that long term stasis in the biliary tract could lead to an increasing incidence of cholecystitis and cholelithiasis? We are evaluating this question at the present time and, although definite statistical evidence has not been accumulated to support this assumption, our early impression is that

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there is an increased incidence of gall bladder disease following vagotomy.

Griffith and Stavney[3] reported that vagal denervation of the small bowel resulted in stasis. They demonstrated that stimulation of thoracic vagi in dogs induced contraction of the small bowel and this contraction remained after selective vagotomy but was greatly diminished after total vagotomy or division of the posterior branch of the vagus nerve.

Wright[6] demonstrated a cephalic phase of secretion of the succus-entericus and possibly alternations in the secretions of the small bowel may explain some of these symptoms. Pancreatic insufficiency, occurring following vagal denervation of the pancreas, may be responsible for the diarrhea. Pfeffer[7] demonstrated in patients, pre and post-vagotomy, that maximum stimulation with insulin hypoglycemia and secretion resulted in a total decrease in amylase output of the pancreas of 337% after vagotomy. McGee[8] presented further supportive work, under controlled conditions, in which partial pancreatic fistuli were created and dogs were studied pre and post-vagotomy. In the post-vagotomy phase they showed a 50% decrease in pancreatic output. Histologic studies of the vagus nerves reveal that 90% of the fibers in the vagus nerve are afferent while only 10% are efferent. So would it not be possible for many of the afferent fibers coming from the pancreas to elicit reflexes that might result in secondary hormonal alterations in gastro-intestinal physiology? This is an unanswered question. Thus, there is a rational physiologic basis on which to explain most of the post-vagotomy symptoms and the evidence is quite good that total vagotomy certainly produces physiologic abnormalities in the biliary tract, small bowel and pancreas.

Anatomy

The operative procedure, with proper exposure, is not difficult. A good understanding of the anatomy of the vagus nerve is essential to the procedure. Although there are multiple anomalies in the vagus nerve division and distribution above the diaphragm the present remarks will be confined to those abnormalities occurring below the diaphragm. In general, the anterior branch comes through the diaphragm to the cardiac portion of the stomach, giving off small esophageal branches and then cardiac branches on down to the stomach. (Figure 1)

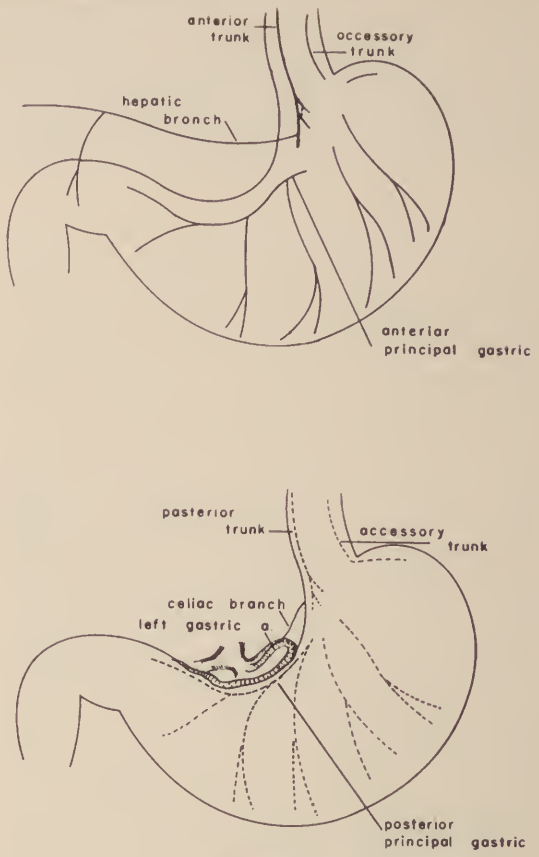

Figure 1.

The hepatic branch is separate, extending over to the porta hepatis and gives off a small branch down to the pylorus. The posterior branch also comes down to the cardiac position of the stomach, giving off its esophageal and gastric branches and extends down to the left gastric artery. At the level of the left gastric artery, it passes along it to the celiax axis, giving off the celiac branch of the vagus. By dividing all the smaller branches of the anterior vagus, preserving the hepatic branch, and severing all the branches of the posterior vagus but preserving the celiac branch, there will be no residual vagal fibers going to the stomach. This has been proven, not only in anatomic studies but in the clinical course of patients who have had selective vagotomy, as well as in multiple experimental studies on animals in which the vagus distribution is similar. As far as can be demonstrated, there are no vagal fibers coming back from the celiac plexus to innervate the stomach.

The operation for performing selective gastric vagotomy is thus devised for adequate exposure of the esophageal hiatus and once this has been obtained, it is no more difficult than dissection

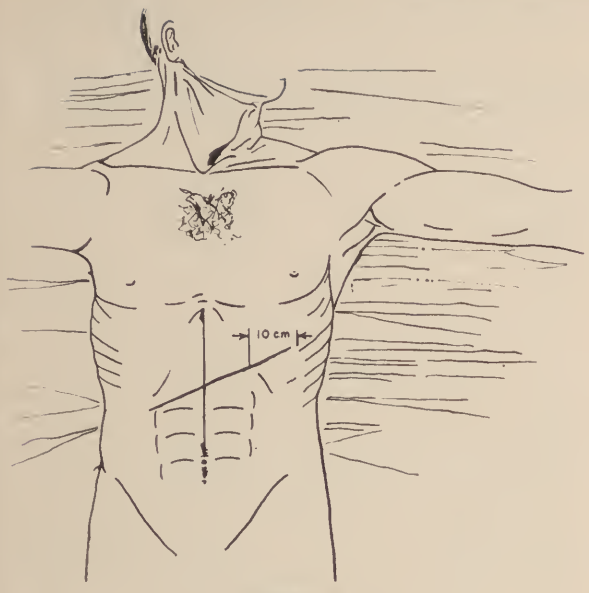

Figure 2.

of the recurrent laryngeal nerves. The incision used is a right subcostal incision extending well up over the left chest wall as recently described by Kraft and Fry[9]. (Figure 2) By carrying it well over the chest wall anteriorly and posteriorly beneath the costochondral junction, considerably more exposure of esophageal hiatus is obtained. Once this has been accomplished, the stomach is placed on tension, drawn caudally and to the left, placing the lesser omentum on tension. In this manner the hepatic branch of the anterior vagus can usually be visualized and easily palpated. The hepatic branch is then preserved and the gastric branches quickly and easily incised completely, freeing the anterior branch. The posterior branch is then identified and is followed down to the left gastric artery dividing all the gastric branches from it going to the stomach. From the left gastric artery it is followed to the celiac axis. Once this procedure has been followed, one can feel with assurance that a complete gastric vagotomy has been obtained. There are no known vagal pathways, by either anatomical or experimental studies, as previously stated, which suggest that vagal innervation can occur retrograde from the celiac axis. Thus, this is an anatomically feasible procedure, which can be performed with proper exposure but requires a complete knowledge of the anatomy of the region.

Results

The results of this procedure have been uniformly good.[2, 3, 4] The 12-hour overnight gastric acid studies, post-operative body weights, morbidity and mortality are the same, or better than those of total vagotomy.

Post-operative Hollander studies have been positive in approximately 5% in contrast to 12-25% following reported series of total vagotomy. It is felt by those utilizing this technique that the increased incidence of achlorhydria following selective vagotomy is due to better exposure and careful identification of all vagal fibers going to the stomach. A surprising but encouraging result has been that a better gastric vagotomy has been performed by the selective technique. The magnitude of the operative procedure has averaged 12 minutes more.

The duodenal content measured in response to insulin hypoglycemia pre and post-operative shows a reduction in amylase and bicarbonate concentration following total vagotomy but with no significant decrease after selective vagotomy. The incidence of diarrhea is definitely decreased.

In the past two years we have done this operation on 17 patients. They all have had negative 12 hour post-operative overnight gastric acid secretions and all are asymptomatic except for one with a mild, typical "Dumping Syndrome."

That the procedure is safe and effective no longer remains a question but further careful follow-up is necessary to establish its final role in the treatment of ulcer disease.

Summary

1. The post vagotomy syndrome is one of vague abdominal discomfort, recurrent episodes of abdominal distention and bloating, intermittent episodes of borborygmi and diarrhea.

2. Selective gastric vagotomy is a safe effective method for interrupting the vagal innervation to the stomach.

3. The rationale of selective vagotomy has been discussed with attention to the poorly understood physiologic alterations following vagotomy.

4. Reduction in post-vagotomy symptoms is becoming apparent as experience increases with this technique.

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The Role and Contributions of a State Mental Health Department to Community Mental Health*

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A review of the philosophy and organization of the Kentucky Department of Mental Health with respect to community mental health.

LADIES and gentlemen, distinguished physicians and members of the Kentucky State Medical Association, it is a distinct honor and pleasure to be here this afternoon to present this short inventory of the role and contributions of the State Department of Mental Health to community mental health.

We all know how far we have come in recent years in the treatment of mental and emotional disorders. We are all aware of the extremely high incidence of such disorders. Medicine as a whole, and psychiatry as a part of medicine, has found it increasingly difficult to supply even remotely adequate service to meet this demand. The supply and demand problem is seemingly without end, and as we improve treatment and facilities, the successes produced generate hope and more demand in others. Throughout the United States, the departments of mental health are finding this situation to be only too true. As of this date, there is no community of any size, or organization in the United States which has an adequate supply of psychiatric care in terms of both quality and quantity.

Three Services

The departments of mental health in the United States were created to meet a need of the people. Many years ago, this need of the general public was expressed as protection for and from mentally ill persons. People wanted not to accept emotional disorders as a fact, and their fears and everyone's general ignorance of the nature and causes of mental difficulties led to this denial. At any rate, most state departments of mental health were primarily organized for the purpose of custodial care. Little money or attention was given to the role of investigator or promoter of better mental health. But as we have noted, the role of mental health departments is changing rapidly. These departments must supplement and support private and local facilities. They never can and never have supplanted local and private facilities. They are not intended to do so.

The Department of Mental Health in this State, for instance, has organized itself to provide three distinct but inter-related services to the people of the State. The Department still basically fulfills the role of caretaker for many, but we now seek to provide services in other ways.

The first service is through the provision of hospital facilities for patients who cannot avail themselves of private treatment—whether it be on the basis of economics or non-availability of such private treatment.

Secondly, the department seeks to provide direct and indirect service at the local level through therapy, consultation, information and education. Third, the Department attempts to add to the general knowledge of the problems through study of the situations with which it deals.

On the community level, many state departments have a separate division of community service, which is non-hospital based. Such a division was established by Kentucky in 1952, and is designed to provide service to communities. The philosophy has been to help the community anticipate its needs in mental health and to aid them in securing and utilizing facilities.

Almost as soon as the first community mental health center was established in this State, it became apparent that the needs would overwhelm any possible direct therapeutic services that

* *Presented September 24, 1963 at Lexington during the KSMA Annual Meeting.*

** *Regional psychiatrist, Eastern Kentucky, Kentucky Department of Mental Health*

might be offered. In a kind of "agonizing reappraisal" the concept of individual case work had to be changed to the concept that in the communities mental health education would take precedence, and that each community would have to recognize its own needs and endeavor to meet them. With this in mind, the indirect therapeutic service was initiated and is being carried out as extensively as the limited personnel and finances of the Department will allow.

Organization

The Community Services Division provides such service to the state in four basic regions: Western Kentucky, the Louisville Area, Northern and Eastern Kentucky. This division recognizes that the objectives, services and methods of one area are not necessarily the most appropriate in another, and that individual communities have individual health and welfare problems and resources.

Each of these regions has at least one psychiatrist who gives consultation and advice to both professional and lay groups as it may be requested. Within this doctor's limits of time and area coverage, he sees as many patients as possible. Many Social Security and Public Assistance evaluations are made in this manner. Referrals from local physicians, school boards and public health nurses are seen and the patients returned to their supervision.

But beyond direct patient contact is the broad program contribution to community mental health. Basically, it is designed to provide services which will promote positive, or preventive, mental health practices. This program affirms the basic medical tradition of the United States that the individual, his family, or his immediate community should provide treatment services—not the government.

In some eighteen communities throughout the State, there are now located some part time consultative and/or treatment centers. Many of these consist only of a trained psychiatric social worker residing in the community and visited by a regional psychiatrist on a regular schedule. Others are only visiting clinics. But in those communities, the psychiatrist, social worker, and other Department personnel are actively giving casework service, resource contacts, public education and information, training and coordination. They cooperate with people from many other departments, organizations and groups in the establishment of workshops, visiting lecturers, consultation, and mass media distribution of information. Community Services personnel work with private and public health physicians, courts, ministers, schools, social agency staffs and the colleges and universities as well as our schools of medicine. They seek to teach positive mental health in order to prevent mental and emotional disorders as well as to give help for that which already exists.

Diagnostic and referral help is given whenever possible, and stimulation of citizen action groups such as mental health associations, mental retardation associations, etc., to provide organization and funds for further services is an important part of the program. Community Services' sibling unit, the Division of Mental Retardation, is working in identical fashion to provide similar services for mentally retarded persons. Two institutions are operative now for in-patient care and training.

This unit does not establish separate centers, but coordinates its community efforts closely with the established centers.

In eastern Kentucky, the community mental health centers are established at Lexington, Ashland and Somerset. To date, these centers are only beginning to get public support and have been entirely supported by State funds. In Western and Northern Kentucky, the centers are older and are partly supported by civic action. Many of them are counseled by advisory boards drawn from the local Mental Health Associations.

Louisville, of course, has a wealth of available coordinating agencies and is supported by both local and State funds.

In all the regions, the resident personnel and communities are aided by visiting teams of specialists in psychiatric nursing and school mental health consultation. These highly trained nurses and consultants coordinate their efforts with the local department personnel to arrange workshops, films, lectures and conferences for professional people having to deal with mental health problems and similar programs for lay persons. Educational television programs dealing with mental health will soon be seen statewide.

Still another community service is provided by the hospitals themselves. On a periodic basis, traveling teams of physicians visit regular posts to provide follow-up care for patients who have

returned to their homes from the hospitals. Day-care facilities at the hospitals will also be available soon.

Psychologists of all divisions of the state department attempt to help communities with evaluation of their candidates for special education classes. Consultant psychiatrists and psychologists from other areas are hired whenever they and funds are simultaneously available, and they fill in the gaps in our organization. Many state-wide meetings and conferences have been held with interested persons with regard to stimulating local participation and interest in the development of more adequate resources. County medical societies are involved as much as possible through the regional psychiatrist and their help to resident social workers has been invaluable.

In the future, it is hoped that matching federal-local funds plans will provide the cornerstone for really great progress in community mental health efforts and the Department of Mental Health will be ready and waiting to contribute any time, skill, and energy it may have available.

Manuscript Memos

Manuscripts should be submitted in duplicate to The Journal of KMA, an original copy and one carbon, and typed with double spacing. Maximum length of an article should not exceed 4500 words; the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

In submitting a manuscript, the author is requested to include a concise summary, not to exceed 35 words, to be used as a sub-title when the article is published in The Journal. The purpose of the summary is to create additional interest and encourage greater readership.

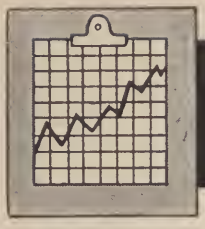
Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus published by the American Medical Association. This requires in the order given: name of author, title of article, name of periodical, with volume, page, month—day of month if weekly—and year. The Journal of the KMA does not assume responsibility for the accuracy of references used with scientific articles.

All scientific material appearing in The Journal is reviewed by the Board of Consultants on Scientific Articles. The editors may use up to six illustrations, with the essayist bearing the cost of all over three one-column halftones.

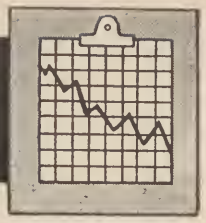
Arrangements for reprints of an article should be made directly with the publisher of The Journal, Gibbs-Inman Printing Company, 817 W. Market St., Louisville, Ky.

The bylaws of the Kentucky Medical Association provide that all scientific discussions and papers read before the KMA Annual Meeting shall be referred to the KMA Journal for consideration for publication. The bylaws further state that the editor or the associate editor may accept or reject these papers as it appears advisable and return them to the author if not considered suitable for publication.

Please mail your scientific articles to The Journal of the Kentucky Medical Association, 3532 Janet Ave., Louisville, Kentucky 40205.



CASE DISCUSSIONS
From The
University of Louisville Hospitals



Eclampsia: A Case Report

JOHN L. DUHRING, M.D.* AND DONALD EDGER, M.D.*

THE exact incidence of eclampsia in the United States today is essentially unknown, but with improving prenatal care the incidence is certainly declining. However, most obstetricians would agree that even under optimal conditions an occasional sporatic case will be seen. In its role as a referral center, the University of Kentucky Medical Center's Obstetrical Department has seen many complications of pregnancy including eclampsia. The following case is presented because of its typical course and as an example of a regimen of management.

Mrs. D. B., a 17-year-old primagravida (EDC 10-2-63) was admitted to the University of Kentucky Medical Center at 4:30 p.m., 9-26-63 in a semicomatose, agitated condition. She had initially consulted her family physician for prenatal care 7-4-63. At that time her weight was 141 lbs., and her blood pressure was 120/80. It was noted that she was doing well. She was then seen subsequently about every two weeks with blood pressures in the range of 140 to 160 systolic over 90 diastolic. She gained 31 pounds over the next 11 weeks with demonstrable edema despite oral and parenteral diuretics. However, albuminuria was never a prominent feature in her course.

When seen on 9-22-63, her weight was 172 lbs., and her blood pressure was 140/90. The cervix was found to be uneffaced and closed. She was to continue on oral diuretics and oral phenobarbital and told to return in two weeks or sooner if necessary.

Apparently the patient was living alone much of the time. However, relatives had seen her early on the morning of 9-26-63 and found her slightly confused but otherwise apparently normal. When they returned at noon, she was unconscious and taken to her family physician's office. He found her blood pressure to be 170/100 and he confirmed the comatose state, although no convulsions were observed. He administered 260 mgs. of pentobarbital and 1.0 gm. of magnesium sulfate parenterally. She was then transferred to the University of Kentucky Medical Center.

On admission it was established that the patient's husband had witnessed at least one convulsion three days prior to admission. When first seen, the patient was agitated and restless with a blood pressure of 160/110, marked hyperreflexia was noted and pitting edema extending from the lower extremities to the thoracic cage was present. Her temperature at this time was 100.4° by mouth and abdominal examination showed a term size fetus with a vertex presenting towards the pelvis. Because the patient's tachycardia in the range of about 140 to 160 per minute, it was impossible to be certain that fetal heart tones were heard at this time. On pelvic examination it was found that the cervix was 1 to 2 cm. dilated and 90% effaced with a vertex presenting at about −2 station. The patient had stridulous respiration and multiple fine rales were heard over both lung bases. Morphine sulfate 10 mgs. was given intravenously, and within a few minutes of admission she had a convulsion. This was controlled rapidly with intravenous amobarbital. Also given were:

Reserpine 5 mgs. 1M
Magnesium Sulfate 10 gm. 1M

Within two hours her blood pressure stabilized at about 120/80 but up to 100 mgs. of amobarbital were required intravenously every hour to control her restless, agitated state. Urinary output, as measured hourly, was the oliguric range (i.e., 0 to 20 cc. per hour). Proteinuria was a prominent feature of her hourly urine analysis running from 2+ to 4+ on a semiquantitative scale. Intravenous mannitol was used in 12.5 to 25 gm. amounts every six hours in an attempt to produce osmotic diuresia. Sixteen hours after admission vital signs were: BP 120/70, P 80, R 24, temp. 100.4° PO. On pelvic examination the cervix was found to be 3 cm. dilated, 80% effaced, with a vertex presenting.

At this time the patient was having irregular mild contractions every 4 to 10 minutes and lasting some 20 to 30 seconds. An amniotomy was performed with the release of deeply meconiumstained fluid. Labor then progressed satisfactorily. A continuous epidural anesthetic was begun, and intravenous oxytocin stimulation was added to the regimen.

After six-and-a-half hours it was possible to deliver a 6 lb. 4 oz. Apgar 3 living male child at 5:22 p.m. on September 27, 1963. The baby was initially depressed and required endotracheal intubation. In the immediate postpartum period the patient maintained normotensive pressures and alternated between coma and agitated delirium.

Approximately 24 hours after delivery her blood pressure began rising to a range of 130 to 160 systolic over 90 to 110 diastolic. Parenteral reserpine was continued in 2.5 mg. doses intramuscularly every six hours. Forty-eight hours after delivery the patient first awoke and could carry out a meaningful conversation with retention of facts presented.

From the department of obstetrics and gynecology, University of Kentucky Medical Center.

Over the next several days she continued hypertensive levels and the reserpine was stopped with no change in her blood pressure. Another facet of the problm was consistenly depressed serum potassium levels, even in the antepartum period when she was oliguric.[1] Accordingly an extensive search for other causes of hypertensoin was instituted, but the patient left the hospital against medical advice before much could be accomplished. Her weight loss from September 22, 1963 through October 6, 1963 was 36 pounds.

This case is typical in several respects, while some atypical aspects were never fully explained. Eclampsia is a fulminating disease occurring largely in primagravidas with limited or inadequate prenatal care. The vast majority of cases are preceded by the characteristic and well-defined changes of pre-eclampsia. The present day armamentarium of diet, drugs, and occasionally hospitalization will control the vast majority of pre-eclamptic patients. The established beneficial effect of salt restriction and/or oral diuretics of the thiazide type is well known. However, in situations such as the case presented, either due to the refractory nature of the disease or lack of patient cooperation, then hospitalization must be utilized if eclampsia is to be prevented.

Regardless of the antecedent factors, once convulsions and/or coma have occurred, hospitalization is mandatory. In this instance, however, there was at least a three day delay due to patient neglect. It is not uncommon for a lucid interval to develop following the initial coma even without therapy as did apparently occur with this patient. When the eclamptic patient is ultimately hospitalized, the definitive therapy is to terminate the pregnancy under such circumstances that will best favor the survival of the mother and baby. All too often the life of the fetus is forgotten or neglected in the face of grave concern for the mother. The maternal mortality in various large, well supervised series seems to be nearly constant. A return to early delivery of the infant has been suggested in order to improve fetal salvage.

All regimens of therapy should be based on the consideration of the basic pathophysiology of the disease. The most recent investigations in this area indicate the common lesion in all organ systems is endarteriol spasm.[2] However, the neural and/or humoral factors producing this vascular spasm have not yet been positively identified. Some experimental work recently reported seems to indicate a humoral factor circulating in the blood and obtainable from the placenta in cases of eclampsia.[3] The exact chemical nature of this substance, or substances, is not yet proven, but may be our first lead to the exact etiology of eclampsia.

The role of magnesium in controlling neuromuscular irritability is well known. Magnesium ions depress not only the central nervous system but the peripheral muscle irritability as well. It is important to note that a wide margin of safety is available in the parenteral use of magnesium. Magnesium levels of 3 to 6 mgs. per cent are considered therapeutically effective in eclampsia while deep tendon reflexes do not disappear until levels of approximately 10 mg. per cent are reached. Respiratory arrest will develop at 12 to 15 mg. per cent and soon thereafter cardiac arrest ensues. It is suggested that even in the face of oliguria, the initial dose of magnesium be 10 gms. (i.e. 20 cc of 50% solution magnesium sulfate). Generally, additional doses of 5 gms. can be given every six hours if deep tendon reflexes are still active. It should also be noted that intravenous administration of calcium solutions will reverse magnesium depression.

Reserpine has been found to be effective in controlling the vasospasm when given in relatively large doses (i.e. 2.5 to 10 mg. intramuscularly or intravenously). The aim of therapy is to reduce blood pressure by a factor of about 25%. This can be achieved in many cases with an initial dose of 2.5 to 5.0 mg. intramuscularly with subsequent doses of 2.5 to 5.0 mg. depending on the individual patient response. Hydralizine is sometimes necessary to control blood pressure when the reserpine response is unsatisfactory. This is best given as intravenous drip containing 60 to 100 mgs. of the drug per 1000 cc. of 5% dextrose in water. The rate of flow must be carefully titrated against the blood pressure as profound hypotension may be produced by this drug. Adequate sedation of the patient is achieved by parenteral administration of short acting barbiturates. However, since most barbituric acid derivatives are excreted through the kidneys, caution must be used in oliguric patients. It is recommended that urinary output be monitored hourly as measured from an indwelling catheter.

Since the kidney is ischemic, extreme caution must be observed in using any of the common diuretic agents. Preferably diuresis is to be encouraged by an osmotic agent such as hypertonic glucose solutions or mannitol. The general support and nursing care of these gravely ill women is of paramount importance. They should be under constant observation with facilities immediately at hand to treat airway obstruction and/or recurrent seizures. Also they should be in a darkened room as free as possible from extrinsic stimuli.

Even after delivery these patients are still gravely ill. They require as much care and attention as prior to delivery. Hypertension, coma, and/or convulsions may still be a problem as long as 48 hours after delivery. As a rule most eclampsia patients will begin to show marked improvement about the second postpartum day. This improvement is frequently first manifested as an increase in the level of consciousness. Blood pressure will begin to assume more normotensive levels, and a spontaneous diuresis will begin. During this phase of diuresis 10 to 12 liters of urine may be excreted per day. This rapid and dramatic fluid loss will, however, frequently severely alter serum electrolytes as fluid is lost on the one hand and mobilized from the extravascular spaces on the other. At these times careful attention must be paid to serum electrolytes, and occasionally supplementation must be given to correct dangerous imbalances.

In summary, the classic management of eclampsia has dictated some fixed, and rather arbitrary period free of convulsions prior to any attempt at effecting delivery. It now seems, however, that if fetal salvage is to be improved, decisive attempts at delivery must be instituted as soon as the mother's condition is sta-

bilized and it seems reasonable to except that she will safely tolerate labor or operative intervention. A wide variety of chemotherapeutic agents are now available to achieve control of the disease and our regimen has been briefly outlined.

Summary of Management for Eclampsia

I. General Measures
   a. Constant observation and frequent vital signs.
   b. Quite darkened room.
   c. Indwelling catheter and hourly urine measurements.
   d. Frequent and inclusive physician evaluation.
   e. Continuous intravenous drip 5% D/W.

II. Airway Protection
   Have immediately available:
   a. Oxygen
   b. Suction
   c. Oral and endotracheal airways
   d. Laryngoscope

III. Antihypertensive drugs
   a. Normotension—nothing
   b. 130-160/90-110: Reserpine 2.5 mg 1M
      Repeat hourly until 25% reduction accomplished,
      Maintain desired level by 2.5 mg - 5.0 mg every 4 to 6 hours.
   c. Over 160/110: Reserpine 2.5 mg 1M
      Hydralazine drip (as described)
      Maintain 25% reduction

IV. Diuretics
   a. Hypertonic dextrose solutions.
   b. Mannitol—12.5 to 50 gms. I.V. every six hours

V. Morphine sulfate to control pain and aggitation as described.

VI. Barbiturates—Short acting agents to sedate as described.

VII. THE CURE: Delivery under conditions to favor survival of mother and fetus.

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SPECIAL ARTICLES

The Aims and Purposes of Medical Assistants*

BETTYE J. FISHER**

Evansville, Ind.

IN OUR daydreams, we often receive tokens of esteem from unknown admirers. Today, gentlemen, I bring you verbal evidence of esteem for the members of the medical profession from a known admirer—myself, as a medical assistant—myself, as a member of the American Association of Medical Assistants. Let me tell you, too, of my esteem for the American Association of Medical Assistants.

Like yourselves, these women came together in a common bond, arising from common interests, a desire to share knowledge, to find more knowledge, to establish professional standards, and to face issues in which we have a common concern.

The common interests, the desire to share knowledge and to find more knowledge are all very familiar to you. Although you are well aware of your own professional standards, you may wonder what we mean by professional standards. Briefly stated, the basic objectives of the A.A.M.A. are: to inspire its members to render loyal, more efficient service to the profession and to the public which we serve, to cooperate with the medical profession in improving public relations, and to render educational services for our members. This Association, in its Constitution, declares that *it is not, nor shall it ever become a trade union or collective bargaining agency.*

Our Association is relatively young, but today I stand before you representing over 12,000 members of my Association, with active chapters in forty-one affiliated states, including Hawaii and Alaska, and with several sister chapters in Canada. One of my greatest privileges as president of A.A.M.A. was chartering the Kentucky State Association of Medical Assistants in 1962, with active chapters in Louisville, Frankfort, and Elizabethtown.

We are seeking advancement through self-education, the immediate reward being increased self-respect. Many of us for years yearned for some means of equipping ourselves to better serve you, and the facilities available scarce—in some instances nonexistent. So, with typical American, and I might say medical, ingenuity, we set out to do something about it. We established local organizations of medical assistants and invited persons knowledgeable in various fields to come instruct us in areas in which our knowledge was inadequate. This served to pique our interest—we couldn't learn fast enough this way, so with the encouragement of our state and national associations, we accelerated our programs through workshops, symposia, college and junior college courses.

Gentlemen, we share your real concern for the protection of the private enterprise system in the United States today. In 1961, as presiden tof A.A.M.A., I appeared before the House Ways and Means Committee in Washington, D.C., to testify on behalf of our members in opposition to the King-Anderson Bill. And I might add that our testimony was in direct conflict with that of the American Nursing Association who had testified in favor of this measure. Just a few months ago, our president, Mrs. Judy Coleman, and our immediate past-president, Miss Alice Bundy, appeared with Doctor Annis and Doctor Welch before this same Committee to reiterate our opposition to H.R. 3920,

**Presented before the September 28 House of Delegates meeting of the Kentucky Medical Association during the 1964 Annual Meeting in Louisville.*

***Mrs. Fisher is a past-president of the American Association of Medical Assistants and has been a frequent visitor to Kentucky in this connection.*

and any other form of socialized medicine. We feel privileged to stand and be counted with you—as persons with special knowledge—on such a vital issue.

Yes, we share your concern, and pledge our continuing support of protection of the people of the United States against further encroachment on the rights of the individual, and further removal of the incentive of private endeavor. Through efforts of a very active Legislative Committee, A.A.M.A. has the past few months made personal contact with each member. We have requested her to write her Congressman and we also suggested she give the "Boss" a gentle nudge and see that his letter was in the mail, too. In one small chapter of 35 members, I know that medical assistants were directly responsible for over 300 telegrams being sent to Washington to oppose socialized medicine.

The American Association of Medical Assistants has come a long way in its brief seven years . . . but it has not come alone. Along the way it has picked up support, the most cherished of which is the American Medical Association, whose members have asked us time and again, "How can we help further your cause and aims?" The answer is simple, gentlemen. If you believe in our purposes, if you believe that our 12,000 members, multiplied many-fold, could benefit you individually, and therefore, collectively—as the Kentucky State Medical Association—then we ask you: give us your help *Individually*. When you go back home, spread the word. Encourage the formation of a chapter in your county if there is none; encourage your medical assistants to join if there is one, and then work with them!

And, please, tell others that we are not, nor shall we ever become a trade union or collective bargaining agency. Just as you do not want a third party in the physician-patient relationship, we do not want a third party in our employer-employee relationship! Let me share with you a creed, which I feel typifies our feeling about protecting our share of that valuable American right . . . *free enterprise*:

I do not choose to be a common man or woman;
It is my right to be uncommon, if I can.
I seek opportunity—not security.
I do not wish to be a kept citizen, humble and dulled by having the state look after me.
I want to make the calculated risk; to dream and to build; to fail and succeed.
I refuse to barter incentive for a dole.
I prefer the challenges of life to the guaranteed existence; the thrill of fulfillment to the stale calm of Utopia.
I will not trade freedom for beneficence, nor my dignity for a handout.
I will never cower before any master nor bend to any threat.
It is my heritage to stand erect and proud and unafraid; to think and act for myself, enjoy the benefits of my creations and to face the world boldly and say,
This, with God's help, I have done!
All this is what it means to be an American.

And this is what it means to me to be a member of the American Association of Medical Assistants.

Won't you gentlemen help us . . . To help you?

Diabetes – An Old Enemy*

ROBERT HENDON, M.D.**
Louisville, Ky.

WHETHER you are a member or a guest I commend your interest in diabetes. Whether you are a specialist or generalist, a consideration of diabetes must obtrude itself into your work.

I believe we are beginning to learn something about this mysterious disorder called diabetes mellitus. We have left behind the old idea that all hyperglycemia is diabetes. We have learned that there are at least two, perhaps more, varities of the disease. We have drawn away from the view that the problem is merely one of not enough insulin.

While the diagnosis of "pre-diabetes" can be made only in retrospect, we have found means to unmask latent diabetes, and so, in part, to learn the reason that the chronic complications of diabetes may be found some time before obvious carbohydrate intolerance.

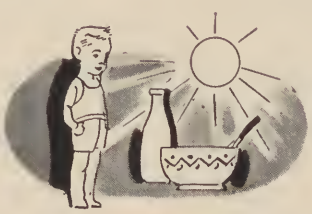
We are currently considering the possibility that this carbohydrate intolerance may be a somewhat secondary manifestation—that the essential pathology centers elsewhere. At any rate, latest estimates suggest that there are in the neighborhood of 4,000,000 diabetics in the United States.

The facts are that the annual death rate from diabetes in this enlightened age is 16.4 per 100,000, placing it as the seventh most frequent cause of death. Although there may be some dispute concerning treatment, the weight of evidence indicates that good control of the diabetic state goes hand in hand with greater life expectancy.

In view of these considerations, the membership of the Kentucky Diabetes Association is dedicated to a quest for new information about the disorder, to the sharing of knowledge with colleagues anywhere, and to teaching recognition and control wherever we can. We are interested in the formation and the activities of the associations of laity concerned with diabetes. We are working toward the establishment of a summer camp in Kentucky for diabetic children.

We welcome the active participation of any and all physicians to these ends.

Presented as the welcoming address to the Kentucky Diabetes Association at its annual meeting, held in Louisville September 28, 1964, in conjunction with the 1964 Annual Meeting of the Kentucky Medical Association.



EDITORIALS

Everybody's Doin' It Now

IT DOES not add to a physician's happiness to feel that some of his colleagues are looking over his shoulder all of the time evaulating the thoroughness, completeness or quality of his work. It has come to pass in recent years, however, that this is the order of the day. It can probably be charged mostly to activities of hospital accreditation agencies that tissue committees, medical appraisal committees and insurance committees have come into being and are necessarily now part of the duty of every medical staff, if the hospital concerned is to maintain accreditation.

It may be some consolation to feel that while your colleagues are watching your work and referring your records back to you with various criticisms, that in the next year you may be doing exactly the same thing for them. It is not a desirable task and most of us would prefer to be on the receiving rather than on the giving end of this type of activity. It is, however, essential in the present day operation of hospitals and must be accepted with as much grace and equanimity as one can muster.

Much has been said in criticism, quite a bit of which is unjust, of the medical profession in recent years, but this has led to a more thorough-going effort to monitor our own conduct. County and state medical societies are more concerned with the professional conduct and the ethical standards of their members than with the minutiae concerned with their records. Various judicial or grievance committees seem to be an essential part of every organized body of physicians. These commitees are usually without disciplinary powers except upon a purely local level and effect no punitive action beyond reprimand and curtailment of hospital privileges or revoking of membership.

These methods of correction cannot be taken lightly. To interfere with or seriously handicap the physician's professional activity or pursuit of his livelihood is a very serious measure and should never be done except in the most extreme and intractable instances of misconduct.

Criticism or censure with regard to fees is a very ticklish function. Since there are no established schedules of fees for physicians and since almost every medical or surgical service is different in scope and time consumed and importance to one's health, it is a most difficult matter to appraise. If any committee concerned with this phase of practice is able to bring about harmony and understanding and agreement between the physician and his patient involved it is generally considered to have accomplished its purpose.

The more serious and persistent instances of misconduct or unprofessional practices which resist satisfactory settlement by local committees eventually may come to the attention of the State Board of Health which is in fact the ultimate or final court of judgement; this board alone is empowered to effect disciplinary action, the suspension or revocation of license, and the removal of a physician from practice.

Many physicians and a greater number of persons outside our profession become impatient and intolerant of the reluctance of the State Board of Health to pass final judgement on the physician and remove him from practice even when his conduct seems to richly deserve it. It must be remembered, however, that patience, and charity must govern the actions of this body.

The present State Board of Health is composed of physicians and some non-physician members. Preference has often been expressed that disciplinary action on physicians should be conducted by physicians only, and considerable thought has been given the establishment of a disciplinary board in the State Medical Association composed only of physicians to whom cases of unprofessional conduct would be referred for judgement. There is certainly reasonable merit to this proposal. To the present date it does not seem that the presence of non-physician members on the State Board of

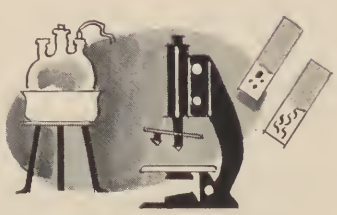
Health has seriously handicapped or curtailed its work, and that by and large over a long period of time this body has performed a creditable service to the profession. Certainly it may be improved and should, by one means or another, become more effective.

During the past two years the Medical Discipline Committee of KMA has given much thought to the creation of a Judicial Council composed of members of KMA with power to subpoena, hear testimony, judge inept medical practices as well as unethical conduct, and be able to enforce disciplinary action such as fines, expulsion from KMA and to recommend through the KMA Board of Trustees that the State Board of Health revoke the offending physician's license to practice medicine. The recommendation of this committee that a Judicial Council for the KMA be created was accepted and implemented at the 1964 meeting.

The question naturally arises whether all of this monitoring has borne good fruit and whether it is worth the time and generally unpleasant effort that it entails. Apparently it has and is. If minor infringements of professional and ethical conduct can be discerned and dealt with at the local level early before they become chronic habits, the physician himself may be saved, his professional career elevated and extended, and the health of the people protected. The more thorough this work is done locally and in its incipiency less often will serious instances of misconduct require more drastic action.

Certainly our hospital records are immeasurably better and the level of professional practice is greatly improved over that of a generation ago. This undoubtedly is due in part to the activities of the hospital accreditation boards and the committees above mentioned. Unquestionably the professional and ethical conduct of physicians in general is better now than it was 50 or 25 years ago. The growing awareness on the part of the profession of this need to correct our own abuses has operated to safeguard more securely the of the people we serve. The medical profession has perhaps led all others in such an effort.

SAM A. OVERSTREET, M.D.



Diabetes Week

AGAIN this year, as in previous years, years, the week preceding Thanksgiving has been designated as Diabetes Week. The Diabetes Detection Drive is a year-round effort to find unknown diabetics and guide them to medical care. The Drive as well as Diabetes Week is sponsored by the American Diabetes Association, founded by and composed of physicians. The Association works through 50 local affiliate Associations and through 900 Committees on Diabetes organized within the framework of State and County Medical Societies.

The year-round effort is featured by an annual nationwide Diabetes Week during which as many persons as possible are screened for diabetes. Last year 96,333 persons were screened for diabetes in the state of Kentucky. Although the exact number of new diabetics detected cannot be accurately ascertained, the number is believed to be in excess of 182. This year, it is hoped, even larger numbers of persons will be tested and more new diabetics discovered than in previous years.

Helping to detect diabetes is one way of giving better medical care to more people. About 3,400,000 Americans are diabetic but roughly half of these are "unknown"—that is their diabetes remains undiagnosed and therefore uncontrolled. Perhaps as many as 5,500,000 more are potential diabetics. On an average of one out of 135 patients that comes into a physicians office will be an unknown diabetic. Every physician wishing to improve the care of his patients will want to detect diabetes as early as possible in the people for whom he is medically responsible.

The postprandial blood sugar is the most effective screening test for diabetes. The Diabetes Committee suggests every physician do postprandial blood sugars on as many of his patients as possible during Diabetes Week, and try to test all patients once a year. Also the physician should tell them the importance of diabetes detection and advise them to have members of their families tested for glycosuria.

The physician may also help to improve statistics on the incidence of diabetes by reporting to the Committee the number of patients tested during Diabetes Week, the number showing glycosuria and the number of these determined to be true diabetics.

The Diabetes Detection Drive can succeed only with the cooperation of the practicing physician. He is the first and main line of detection, as he is the first and only line of treatment. His help is essential if unknown diabetics are to be brought under medical care and thus remain effective members of the community.

ROBERT S. TILLETT, M.D., Chairman
KSMA Committee on Diabetes

ORGANIZATION SECTION

Dr. Baker Chosen by Delegates As KMA President-Elect

Everett H. Baker, M.D., Louisville, was unanimously chosen president-elect of the Kentucky Medical Association at the second session of the House of Delegates in Louisville on September 30.

Dr. Baker

Installed as president was Delmas M. Clardy, M.D., Hopkinsville, who succeeded George P. Archer, M.D., Prestonsburg, in that office.

Doctor Baker, a native Louisvillian, completed his undergraduate work at Vanderbilt University and graduated from the University of Louisville School of Medicine in 1925. A veteran of the USAF, he served during World War II finishing his tour of duty as a Lieutenant Colonel.

Assistant professor of anesthesiology at the University of Louisville since 1947, Doctor Baker became a diplomate of the American College of Anesthesia in 1948. He is a former vice president of KMA (1955-6), a past president of the Jefferson County Medical Society, the Kentucky Society of Anesthesiologists, the Louisville Society of Anesthesiologists, and the Innominate Society. Doctor Baker is presently on the Board of Directors of Kentucky Physicians Mutual.

Newly elected vice presidents are: Robert Lykins, M.D., Louisville, Central; Harold Barton, M.D., Corbin, Eastern; and Kenneth M. Eblen, M.D., Henderson, Western.

J. Thomas Giannini, M.D., Louisville, was re-elected AMA delegate and Charles G. Bryant, M.D., Louisville, was voted another term as alternate delegate to the AMA.

Dr. Quertermous in AMA Post

John C. Quertermous, M.D., Murray, KMA Delegate to the American Medical Association, has been named to serve on a reference committee at the winter clinical meeting of the AMA in Miami November 29-December 1.

Milford O. Rouse, M.D., Dallas, speaker of the AMA House of Delegates, has appointed Doctor Quertermous to serve on the Reference Committee on Legislation and Public Relations.

Delmas M. Clardy, M.D., Hopkinsville, (left) takes the oath of office as new KMA president at the second meeting of the House on September 30. Administering the oath is Douglas E. Scott, M.D., Lexington, chairman of the Board of Trustees.

Drs. Pennington and Chatham to Lead Board of Trustees

Robert E. Pennington, M.D., London, who served KMA as a vice president (Eastern) in 1961-2, was elected chairman of the Board of Trustees at a meeting of the Board in Louisville during the Annual Meeting on October 1. Donald Chatham, M.D., was elected vice chairman.

Dr. Pennington

Doctor Pennington succeeds Douglas E. Scott, M.D., Lexington, as chairman. Active in KMA activities for many years, Doctor Pennington represents the fifteenth district on the Board. He has been secretary of the Laurel County Medical Society and is a member of the American College of Surgeons.

Doctor Chatham, a past president of the Shelby-Oldham-Henry Medical Society, succeeds Gabe A. Payne, Jr., Hopkinsville, as vice chairman.

Newly elected trustees include: W. Gerald Edds, M.D., Calhoun, who succeeds Howell J. Davis, M.D., Owensboro, second district; and Walter L. Cawood, M.D., Ashland, who succeeds Clyde C. Sparks, M.D., Ashland, in the thirteenth district.

Re-elected as trustees were: Donald Chatham, M.D., Shelbyville, seventh district; Mitchel B. Denham, M.D., Maysville, ninth district; Douglas E. Scott, M.D., Lexington, tenth district.

KMA Members Planning to Attend AMA's Miami Beach Meeting

A number of KMA members have made plans to go South for the American Medical Association's 18th Clinical Convention in Miami Beach on November 29-December 2.

KMA Delegates to the AMA—Wyatt Norvell, M.D., New Castle; J. Thomas Giannini, M.D., Louisville; and John C. Quertermous, M.D., Murray—will be among those making the Florida trip. Also planning to attend are Alternate Delegates—Charles G. Bryant, M.D., Louisville; William W. Hall, M.D., Owensboro, and Charles C. Rutledge, M.D., Hazard. Delmas M. Clardy, M.D., Hopkinsville, KMA president, will also be among those attending.

Timely subjects of wide interest will be discussed at the scientific sessions which will be followed by question and answer periods. A comprehensive series of lectures in the obstetrical field will be a highlight of the scientific program. Another important feature of the program will be a series of eight lectures on vascular occlusive diseases on the final day of the meeting. Other major areas to be covered are immunization, depression, cardiac arrhythmias, emphysema, iatrogenic diseases and hypertension.

The entire scientific program, with the exception of fireside conferences, will be held at the Miami Beach Convention Hall. On display will be 125 scientific exhibits, including a special exhibit on fractures.

More than 300 physicians will participate in a full program of lectures, exhibits, motion pictures, color television, fireside conferences and breakfast roundtables.

Nominating Committee Named

A five man nominating committee to select a slate of KMA General officers for 1965 was chosen by the Association's House of Delegates on September 30.

The nominating committee will hold its first meeting at the KMA Interim Meeting in Owensboro on March 18. At that time a chairman will be elected. Members of the committee are: Harold B. Barton, M.D., Corbin; Carl H. Fortune, M.D., Lexington; Russell L. Hall, M.D., Prestonsburg; James M. Riley, Jr., M.D., Louisville; and Paul J. Sides, M.D., Lancaster.

Two Ky. M.D.s in ATS Posts

William H. Anderson, M.D., associate professor of medicine and director of the Pulmonary Center at U. of L., and Kurt W. Deuschle, M.D., professor and chairman of the department of community medicine at U. of K., have been named to committees of the American Thoracic Society.

Doctor Deuschle has been elected to the editorial board of the society's publication, *The American Review of Respiratory Diseases.* Doctor Anderson will serve on the committee on medical education and was also elected to a second term on the society's governing board.

Leaders of the Woman's Auxiliary to KMA talk with the President-Elect of the Woman's Auxiliary to the AMA during the Annual Session. From left to right—Mrs. Richard Sutter, St. Louis, AMA Auxiliary, president-elect; Mrs. J. Jack Martin, Tompkinsville, president, KMA unit; Mrs. Robert J. Salisbury, Mt. Sterling, president-elect KMA auxiliary; and Mrs. J. Murray Kinsman, Louisville, KMA auxiliary immediate past president.

Mrs. Salisbury Chosen Pres.-Elect Of KMA Woman's Auxiliary

Mrs. Robert J. Salisbury, Mount Sterling, was chosen president-elect of the Woman's Auxiliary to the Kentucky Medical Association at the Auxiliary's Annual Convention held in Louisville in conjunction with the KMA Annual Meeting.

She will succeed Mrs. J. Jack Martin, Tompkinsville, who was installed as president for 1964-65. Outgoing president Mrs. J. Murray Kinsman, Louisville, presided at the 1964 meeting at the Kentucky Hotel.

Other new officers include: Mrs. Ballard Cassady, Pikeville, first vice president; Mrs. Charles Kissinger, Henderson, second vice president; Mrs. O. L. May, Danville, third vice president; Mrs. Robert A. Stewart, Ashland, fourth vice president; Mrs. James A. Harris, Paducah, recording secretary; and Mrs. William C. Durham, Louisville, this year's convention chairman, treasurer.

Ky. Diabetes Assoc. Elects

Robert Hendon, M.D., Louisville, presided at the third annual meeting of the Kentucky Diabetes Association in Louisville on September 28. William Winternitz, M.D., Lexington, was chosen president-elect at the association's business session. Other new officers are: Lewis Dickinson, M.D., Glasgow, vice president; Kenneth Crawford, M.D., Louisville, secretary; and Arthur T. Hurst, M.D., Louisville, treasurer.

Featured speaker was William R. Kirtley, M.D., who spoke on the "Newer Concepts of Insulin". Other speakers were Maurice Best, M.D., Kenneth Crawford, M.D., and Harold Kramer, M.D., all of Louisville, and John Selby, M.D., Lexington. The Jefferson County Lay Diabetes Association joined with the KDA at a lucheon where Doctor Kirtley spoke on "Oral Hypoglycemic Agents".

Faculty Scientific Achievements Awards were presented at the President's Luncheon at the Annual Meeting. At the left is John W. Brown, Ph.D., University of Louisville Medical School's chairman of curriculum, recipient of the U of L Award. At right is Dean William R. Willard of the University of Kentucky Medical Center who accepted the U of K award for Frank C. Spencer, M.D., Lexington, who was in California.

Drs. Brown, Spencer Honored With KMA Faculty Awards

John W. Brown, Ph.D., associate professor of biochemistry at the University of Louisville, and Frank C. Spencer, M.D., professor of surgery at the University of Kentucky, received the 1964 Kentucky Medical Association Faculty Scientific Awards at the President's Luncheon September 30 during the KMA Annual Meeting in Louisville. William R. Willard, M.D., Dean of the U. of K. College of Medicine, accepted the award for Doctor Spencer, who could not be present.

The awards, presented this year by William Bizot, M.D., Louisville, chairman of the KMA Awards Committee, were established in 1962 in order to recognize facultly members from Kentucky's two medical colleges for outstanding research or other significant contributions.

Doctor Spencer came to Lexington in 1961 from Johns Hopkins University School of Medicine. Before the University of Kentucky Hospital opened, he was engaged in research which set the stage for later clinical experimental triumphs. He was recognized for his achievements in the field of open-heart surgery, in teaching and in leadership within his department and the Medical Center.

Doctor Brown, who became associated with the University of Louisville School of Medicine in 1957, has served from 1962 until the present as associate director of Commonwealth Curriculum Study. He served as chairman of the Curriculum Committee which developed the new curriculum program at the U. of L. School of Medicine. He was honored for his leading role in the planning of the new curriculum and his outstanding contributions as a teacher.

President's Luncheon Speaker Prescribes Dose of Laughter

A sense of humor is a prime requisite in learning to face our problems, Charles W. Jarvis, Texas dentist-humorist, told a crowd of 265 attending the 1964 KSMA Annual Meeting President's Luncheon at which he was the main speaker.

"So—You Have a Problem?" was the topic of Doctor Jarvis' highly entertaining talk before Kentucky physicians and their guests at the September 30 luncheon held in the Terrace Room of the Kentucky Hotel in Louisville.

"Everyone has problems", said Doctor Jarvis, who also remarked that the problem of medicare has everybody confused. "Government intervention into medical care will not benefit anyone", he stated, and added, "Today America is recognized as the paragon of medical care . . . that is because it has been left alone. I really believe that incentive and initiative mean something."

Continuing this subject, the San Marcos, Texan, who is a member of the AMA Speakers Bureau, remarked that incentive and initiative are not encouraged by governmental direction and manipulation.

In closing the address that kept his audience laughing for its duration, Doctor Jarvis reminded the crowd that "We can thank God for a sense of humor. We have problems, but we can still laugh at them."

The President's Luncheon at the 1964 Annual Meeting was regarded as an outstanding success. Shown above is a portion of the speaker's table during the Luncheon which was held in the Terrace Room of the Kentucky Hotel.

Ky. Physicians Slated to Speak at SMA Meeting in Memphis

Thirteen Kentucky physicians are scheduled to speak at the 58th Annual Meeting of the Southern Medical Association in Memphis, Tenn., on November 16-19, according to J. Duffy Hancock, M.D., Louisville, a member of the SMA Board of Trustees.

Assisting the Committee on Scientific Work in preparing an "outstanding" scientific program were the section secretaries, including Douglas M. Haynes, M.D., Louisville, Section on Obstetrics, Andrew M. Moore, M.D., Lexington, Section on Plastic & Reconstructive Surgery, and Herman Wing, M.D., Louisville, Section on Industrial Medicine and Surgery. Sam A. Overstreet, M.D., Louisville, is on the SMA Council.

The meeting will feature three symposia, daily color TV, scientific and technical exhibits, and many scientific presentations. On the social side, there will be a President's Luncheon, Hospitality Hour, President's Dinner Dance, golf tournament. There will be a social hour for U of L medical alumni on Tuesday, November 17, at the Hotel Peabody, Tennessee Room, at 6:30.

"Office Management of Smoking Deterrents in the Adolescent" will be discussed by Irving B. Perlstein, M.D., Louisville, as part of a symposium on the "Problems of Adolescents" on November 19.

Participating in the Section of Gynecology will be A. J. Whitehouse, M.D., Lexington, and Laman A. Gray, M.D., Louisville. Doctor Whitehouse will speak on "The Systemic Uterine Curettage" on November 17 and Doctor Gray will speak on "Treatment of Endometriosis of the Large Bowel: Excision or Castration?" on November 18.

Herman Wing, M.D., and Thomas Marshall, M.D., will present "Arthropathies of the Hand: Clinical and Radiographic Diagnosis" before the Section on Industrial Medicine and Surgery and the Section on Physical Medicine and Rehabilitation on November 17.

At the Section on Medicine on November 18 Jerome E. Cohn, M.D., Lexington, will participate in a panel on "Pulmonary Function Testing and the Management of Chronic Pulmonary Disease". "The Surgical Management of Exophtalmos" will be discussed by Roderick MacDonald, Jr., M.D., Louisville, at the Section on Ophthalmology.

Paul Weeks, M.D., Lexington, will talk on "Injuries of the Digital Extensor Apparatus" at the Section on Plastic and Reconstructive Surgery on November 16. At the Section on Preventive Medicine Jesse W. Tapp, M.D., will be the discussant on "Infectious Hepatitis: Report of a Community Epidemic", on Tuesday, November 17.

Moderator of "Cardiac Surgery" on closed circuit TV on Tuesday, November 17 will be Frank Spencer, M.D., Lexington. Also participating in the Section on Surgery will be Gordon L. Hyde, M.D., Lexington, who will speak on "Selective Gastric Vagotomy".

John Harter, M.D., Louisville, will discuss "Postoperative Cardiopulmonary problems at a joint session of SMA and the Southern Chapter, American College of Physicians on November 16.

Following the President's Luncheon recipients of KMA's three major awards gather to take a closer look at their awards. From left to right—Lloyd Hall, M.D., Salyersville, Outstanding General Practitioner Award; Betty Wilson, Owensboro, R. Haynes Barr Award; William Bizot, M.D., Louisville, chairman of KMA Awards Committee; and Gaithel L. Simpson, M.D., Greenville, Distinguished Service Medal.

Drs. Simpson and Hall Honored by KMA at Annual Meeting

Gaithel L. Simpson, M.D., Greenville, and Lloyd M. Hall, M.D. Salyersville, were recipients of the two top KMA awards at the President's Luncheon on September 30.

Doctor Simpson, president of the KSMA in 1961-62, was awarded the Association's Distinguished Service Medal and Doctor Hall received the Outstanding General Practitioner Award.

A 1931 graduate of the University of Louisville School of Medicine, Doctor Simpson has served KMA in many capacities including serving as vice chairman of the Kentucky Rural Scholarship Loan Fund since the program began in 1946. He was chairman of the KSMA Medical Services Committee when it surveyed the state and sponsored the indigent care program in Kentucky.

Doctor Simpson is currently a member of the Board of Directors of the Kentucky Chamber of Commerce and has served as chairman of the Governor's Advisory Council to the Indigent Medical Care Program since its inception in 1961. He has testified twice before the House Ways and Means Committee for KMA against the King-Anderson Bill. He is also widely known for his conservation work.

Doctor Hall, Magoffin County's only practicing physician, has been in general practice in Salyersville for 31 years. He graduated from the University of Louisville School of Medicine. During the first 12 years of his practice he traveled on horseback and then, as the mountain roads improved, graduated to a jeep. He has been County Health Officer for six years and has been chairman of the County Board of Health for many years. He has been medical examiner for the local draft board for 25 years.

Elected Mayor of Salyersville in 1963, he served until moving outside of the city limits recently. He

was instrumental in getting the town its first water works and sewage system. Three years ago he was named "Man of the Year" by the businessmen of the town. He has a son who is a practicing physician, another son a senior medical student and his wife is a registered nurse.

This year's R. Haynes Barr Award was given to Mrs. Betty Wilson, Owensboro, leader of a four piece combo that has provided music for servicemen, hospitals, and rest homes for almost 40 years. Every Sunday for 23 years she and her orchestra have played at the former Veterans Hospital at Outwood.

Kentuckians to Participate in AMA Mental Health Congress

Two Kentuckians, Beverley T. Mead, M.D., assistant professor of psychiatry at the University of Kentucky, and Robert G. Cox, KMA executive assistant, will participate in the American Medical Association's Second National Mental Health Congress at the Palmer House in Chicago November 5-7.

Doctor Mead is co-chairman of a workshop section on enlisting community support for mental health in rural areas. This will be a part of one of 14 workshop sessions planned for the second day of the three-day Congress. Mr. Cox, who has been active in local and state mental health programs, will deliver an address on the role of county and state medical societies in community mental health during another session.

Also on the program will be Harold L. McPheeters, M.D., former director of the Kentucky Department of Mental Health, now with the New York Mental Health Department.

Mental Health Digest Ready

A summary of the Digest of Proceedings of the first Kentucky Congress on Mental Health sponsored by the Kentucky Medical Association is now available on request from the KMA Headquarters Office.

The summary was prepared by the Kentucky Association for Mental Health, one of the co-sponsors of the Congress, and is being mailed to all Congress participants. The Congress was held in Louisville, Thursday, May 14.

Message Center A Success

Approximately 350 messages were handled by the message center at the 1964 KMA Annual Meeting. This is the first time a central message center has been used at the meeting and comments on its efficiency and convenience indicate its success.

The center, which was manned by trained employees of the Yellow Pages Department of the Southern Bell Telephone Company, received special praise from the KMA House of Delegates.

Principal participants in the KEMPAC banquet on Monday evening, September 28 were George P. Archer, M.D., Prestonsburg, KMA president; Birch Bayh, Indiana Senator; Donald Wood, M.D., chairman of the Board AMPAC and President of Indiana State Medical Association; Hoyt D. Gardner, M.D., Louisville, chairman of the KEMPAC Board; Senator Frank Carlson, Kansas, who also participated in the program, was not present for the picture.

Senators Bayh and Carlson Speak at KEMPAC Dinner

Two viewpoints of the future of govenment and its relation to the medical profession were presented by Senators Birch Bayh, Indiana Democrat, and Frank Carlson, Kansas Republican, to the 285 physicians and their guests who attended the September 28 Kentucky Education Medical Political Action Committee Banquet at the Kentucky Hotel in Louisville.

Donald A. Wood, M.D., Indianapolis, chairman of the Board of the American Medical Political Action Committee (AMPAC) spoke on the history and purpose of AMPAC. The diners also heard an address by George P. Archer, M.D., president of the Kentucky Medical Association.

The annual KEMPAC social hour and banquet were held in conjunction with the 1964 Annual Meeting of the Kentucky Medical Association.

42 Play in 1964 Golf Tournament Dr. Scalzitti is Winner

C. J. Scalzitti, M.D., Louisville, was winner of the KMA Championship Trophy at the annual KMAGA Golf Tournament held during the Annual Meeting of the Kentucky Medical Association in Louisville, September 29 through October 1.

Kenton D. Leatherman, M.D., Louisville, was chairman of the KMA Golf Committee. The tournament, in which 42 members participated, was held at the Big Spring Country Club.

Doctor Leatherman announced the winners, who also included R. Glenn Greene, M.D., Owensboro, Low Net Trophy; Harvey B. Stone, M.D., Hopkinsville, Championship Trophy Senior Division; Henry H. Moody, M.D., Cynthiana, Low Net Trophy Senior Division.

Next year's tourney is tentatively scheduled for the Louisville Country Club. All golfers are urged to make plans for participating in the 1965 tournament which will be held Monday, September 20.

First official act of Dielmas M. Clardy, M.D., Hopkinsville, (left) as KMA president was presentation of the Past President's Key to 1963-64 President George P. Archer, M.D., Prestonsburg.

Was Your Delegate Present?

ROLL CALL—

1964 House of Delegates*

KMA Annual Meeting

OFFICERS

		First Session	Second Session
Speaker	Garnett J. Sweeney	Present	Present
Vice-Speaker	George F. Brockman	Present	Present
President	George P. Archer	Present	Present
President-Elect	Delmas M. Clardy	Present	Present
Vice-President	Carlisle Morse	Present	Present
Vice-President	Carl Cooper, Jr.	Present	Present
Vice-President	John Dickinson	.....	Present
Secretary	Henry B. Asman	Present	Present
Treasurer	Keith P. Smith	Present	Present
Delegate to the AMA	Wyatt Norvell	Present	Present
Delegate to the AMA	J. Thomas Giannini	Present	Present
Delegate to the AMA	John C. Quertermous	Present	Present
Alternate Delegate to the AMA	Charles G. Bryant	.....	.....
Alternate Delegate to the AMA	William W. Hall	.....	Present
Alternate Delegate to the AMA	Charles C. Rutledge	Present	Present

TRUSTEES

District			
First	O. Leon Higdon	Present	Present
Second	Howell J. Davis	.....	.....
Third	Gabe A. Payne, Jr.	Present	Present
Fourth	Dixie E. Snider	.....	Present
Fifth	Alfred O. Miller	.....	.....
Sixth	Rex E. Hayes	Present	Present
Seventh	Donald Chatham	.....	Present
Eighth	W. Donald Janney	.....	Present
Ninth	Mitchel B. Denham	Present	Present
Tenth	Douglas E. Scott	Present	Present
Eleventh	Hubert C. Jones	Present	Present
Twelfth	Thomas O. Meredith	Present	Present
Thirteenth	Clyde C. Sparks	Present	Present
Fourteenth	William C. Hambley	Present	Present
Fifteenth	Robert E. Pennington	Present	Present

PAST PRESIDENTS

Past-President	David M. Cox	Present	Present
Past-President	Gaithel L. Simpson	Present	.....
Past-President	Richard G. Elliott (deceased)		
Past-President	Irvin Abell, Jr.	.....	Present
Past-President	Robert W. Robertson	.....	.....
Past-President	Edward B. Mersch	.....	.....

The information in the Roll Call was taken from the attendance record cards signed by the delegates prior to the meetings of the House on September 28 and 30.

DELEGATES

First District

County		First Session	Second Session
BALLARD	Glenn Baird	.....	.....
CALLOWAY	Hugh L. Houston	Present	Present
CARLISLE	John T. O'Neill	Present	Present
FULTON	G. F. Bushart	Present	.....
GRAVES	Robert Orr	.....	Present
HICKMAN	V. A. Jackson	.....	Present
LIVINGSTON			
McCRACKEN	R. M. Wooldridge	Present	.....
	W. B. Haley	Present	Present
	G. H. Widener	.....	.....
	O. L. Higdon (Alt.)	.....	Present
MARSHALL	J. R. Miller	Present	Present

Second District

DAVIESS	J. S. Oldham	Present	Present
	W. H. Hall	Present	Present
	B. H. Warren	Present	Present
HANCOCK	B. Pressley Smith	.....	Present
HENDERSON	Julian Cole	.....	.....
	Walter O'Nan (Alt.)	Present	Present
McLEAN	W. G. Edds	Present	Present
OHIO	R. E. Norsworthy	Present	.....
UNION	Wallace N. Bell	Present	Present
WEBSTER	John Logan	Present	Present

Third District

CALDWELL	Ralph Cash	.....	.....
CHRISTIAN	Guinn S. Cost	.....	.....
	R. C. Snowden (Alt.)	Present	Present
	Norma T. Shepherd	Present	Present
CRITTENDEN	R. M. Brandon	.....	.....
HOPKINS	Loman C. Trover	Present	Present
	F. A. Scott	Present	Present
LYON	James E. Hamilton	.....	.....
MUHLENBERG	Hylan Woodson	Present	Present
TODD	R. D. Lynn	Present	Present
TRIGG	John Futrell	.....	.....

Fourth District

BRECKINRIDGE	James G. Sills	Present	.....
BULLITT	R. S. Bowen	Present	.....
GRAYSON	Ray A. Cave	Present	.....
GREEN	J. W. Miller	.....	.....
HARDIN	R. T. Routt	Present	Present
HART			
LARUE	J. D. Handley	.....	.....
MARION	David Drye	.....	Present
MEADE	W. A. Cole, Jr.	.....	.....

Fifth District

JEFFERSON	Frank A. Bechtel	Present	Present
	Sam H. Black	Present	Present
	Elbert G. Christian	Present	Present
	Morgan R. Colbert	.....	.....
	William C. Durham	Present	Present
	Rudy Ellis	.....	.....
	Wilfrid C. Gettelfinger	Present	Present
	A. L. Goodman	Present	Present
	John Hemmer	.....	.....
	David W. Kinnaird	Present	Present

Discussion in the reference committees on Monday afternoon, September 28, following the first meeting of the House of Delegates, was spirited as demonstrated in Reference Committee No. 2 which reviewed the Council on Medical Education and Hospitals and the Council On Scientific Assembly Reports.

	Blaine Lewis	.....	Present
	Richard Mardis	.....	Present
	Homer B. Martin	Present	Present
	George F. McAuliffe	Present	Present
	Robert L. McClendon	Present	Present
	John Moorhatch	.....	Present
	Herman Moore	Present	Present
	Henry W. Post	Present	Present
	Carroll Robie	Present	Present
	W. Fielding Rubel	Present	Present
	James M. Riley	Present	Present
	William T. Rumage, Jr.	.....	.....
	Paul J. Ross	Present	.....
	Bernard Schoo	.....	.....
	Samuel M. Smith	Present	.....
	William B. Stodghill	Present	Present
	Robert C. Tate	Present	Present
	Edward Warrick, Jr.	Present	Present
	Sam Weakley	Present	Present
	John Wolford	.....	Present

Sixth District

ADAIR	M. C. Loy	Present	.....
BARREN	Eugene L. Marion	Present	.....
BUTLER	John C. Burris	.....	Present
CUMBERLAND	Joseph Schickel	.....	Present
EDMONSON			
LOGAN	G. B. Glenn	.....	Present
	C. V. Dodson (Alt.)	Present	.....
METCALFE	P. D. Hitchcock	.....	.....
MONROE	John C. Marsh	.....	.....
SIMPSON	L. F. Beasley	Present	Present
WARREN	Paul Parks	Present	Present
	Martin Wilson	Present	Present

Seventh District

ANDERSON	Boyd Caudill	Present	.....
CARROLL	Edgar S. Weaver	.....	.....
FRANKLIN	John Stewart	Present	Present
	Branham B. Baughman	Present	Present
GALLATIN	J. E. Esteves (Deceased)		
GRANT	C. C. Waldrop	Present	Present
HENRY	S. B. May	Present	.....
OLDHAM	H. B. Mack	Present	Present
OWEN	O. A. Cull	.....	.....
SHELBY	A. D. Doak	Present	Present
TRIMBLE	John I. Cooper	.....	.....

Eighth District

BOONE	L. C. Hess	Present	Present
CAMPBELL-KENTON	Carl J. Brueggeman	Present	Present
	Thomas Huth	Present	.....
	Paul Klingenberg	Present	Present
	R. Charles Smith	Present	Present
	Richard Allnutt	Present	Present
	Robert T. Longshore	Present	Present

Ninth District

BATH			
BOURBON	R. J. Wever	.....	.....
BRACKEN	J. M. Stevenson	Present	Present
FLEMING	L. W. Bowman	.....	.....
HARRISON	Henry Moody	Present	.....
MASON	Harry C. Denham	Present	Present
NICHOLAS	W. R. Kingsolver	.....	.....
PENDLETON	William M. Townsend	.....	.....
ROBERTSON			
SCOTT	J. C. Cantrill	Present	.....

Reference Committee chairmen and secretaries taking the dictation often work into the small hours during the Annual Meeting in order to meet the deadline. Shown above is Lewis Bosworth, M.D., Lexington, dictating the Reference Committee Report on Bylaws to Mrs. Patricia Hire of the KMA staff.

Members of the House of Delegates applaud as Everett H. Baker, M.D., Louisville, KMA president-elect, walks to the podium following his election by the House.

Tenth District

FAYETTE	W. L. Boswell	Present	Present
	N. L. Bosworth	Present	Present
	Harvey Chenault	Present	Present
	Carl H. Fortune	Present	Present
	M. R. Gilliam	.....	Present
	Arnold C. Williams (Alt.)	Present	.....
	A. M. Moore	Present	Present
	T. R. Bryant, Jr.	Present	Present
	Irvin F. Kanner	Present	Present
	J. H. Saunders	Present	.....
	W. L. Burke (Alt.)	.....	Present
	William R. Willard	Present	Present
	John F. Berry, Jr.	Present	Present
	D. B. Stevens	Present	Present
JESSAMINE	J. S. Williams	Present	Present
WOODFORD	Norman Fisher	Present	Present

Eleventh District

CLARK	Earl Rynerson	.....	.....
ESTILL	R. R. Snowden	.....	.....
JACKSON			
LEE			
MADISON	William D. Epling	Present	Present
	William C. Clause	.....	.....
MENIFEE	D. L. Graves	.....	.....
MONTGOMERY	R. J. Salisbury	Present	Present
OWSLEY	Mildred B. Gabbard	.....	.....
POWELL			
WOLFE	Paul F. Maddox	Present	.....

Twelfth District

BOYLE	Chris S. Jackson	Present	.....
CASEY			
CLINTON	Ernest A. Barnes	.....	.....
GARRARD	Paul J. Sides	Present	Present
LINCOLN	H. I. Frisbie	.....	.....
	James Blackerby (Alt.)	Present	Present
McCREARY	H. A. Perry	.....	.....
MERCER	J. H. Baughman	Present	.....
ROCKCASTLE			
RUSSELL	Charles E. Peak	.....	.....
WAYNE	John W. Simmons	.....	.....
	W. R. Kelsay, Jr. (Alt.)	.....	Present

Thirteenth District

BOYD	Walter Cawood	Present	Present
	W. R. Duff	Present	.....
CARTER			
ELLIOTT	John F. Greene	.....	.....
GREENUP	C. B. Johnson	Present	Present
LAWRENCE	A. W. Wright	.....	.....
LEWIS	Elwood Esham	.....	Present
MORGAN	Morris L. Peyton	.....	.....
ROWAN	Herbert Hudnut	Present	Present

Fourteenth District

BREATHITT	Price Sewell, Jr.	.....	.....
FLOYD	Russell L. Hall	Present	Present
JOHNSON	James W. Archer	Present	Present
KNOTT	Gene T. Watts	.....	.....
LETCHER	J. B. Tolliver	.....	.....

Continued on Page 891

When you recognize depression and anxiety traceable to an emotionally charged situation with no somatic disorder

—*start the patient on 'Deprol'*

Typical situations in which 'Deprol' is indicated:

marital or other family problems ■ death of a loved one ■ financial worries ■ fear of cancer, heart disease or other life-threatening illness ■ pre- and post-operative apprehensions ■ retirement problems, and many other stressful situations which cause the patient to feel a sense of loss, guilt or unworthiness

Advantages of 'Deprol'

1. By relieving both depression and anxiety, 'Deprol' lifts the mood of the depressed patient without the agitation and "jitters" that often accompany "energizer" therapy alone.
2. 'Deprol' restores normal sleep, relaxes physical tensions, and improves appetite.
3. 'Deprol' acts rapidly—patients often respond within a week or two.
4. 'Deprol' is relatively nontoxic and free of side effects.
5. When depression and anxiety accompany physical illness, 'Deprol' is compatible with drugs used to treat these organic conditions.

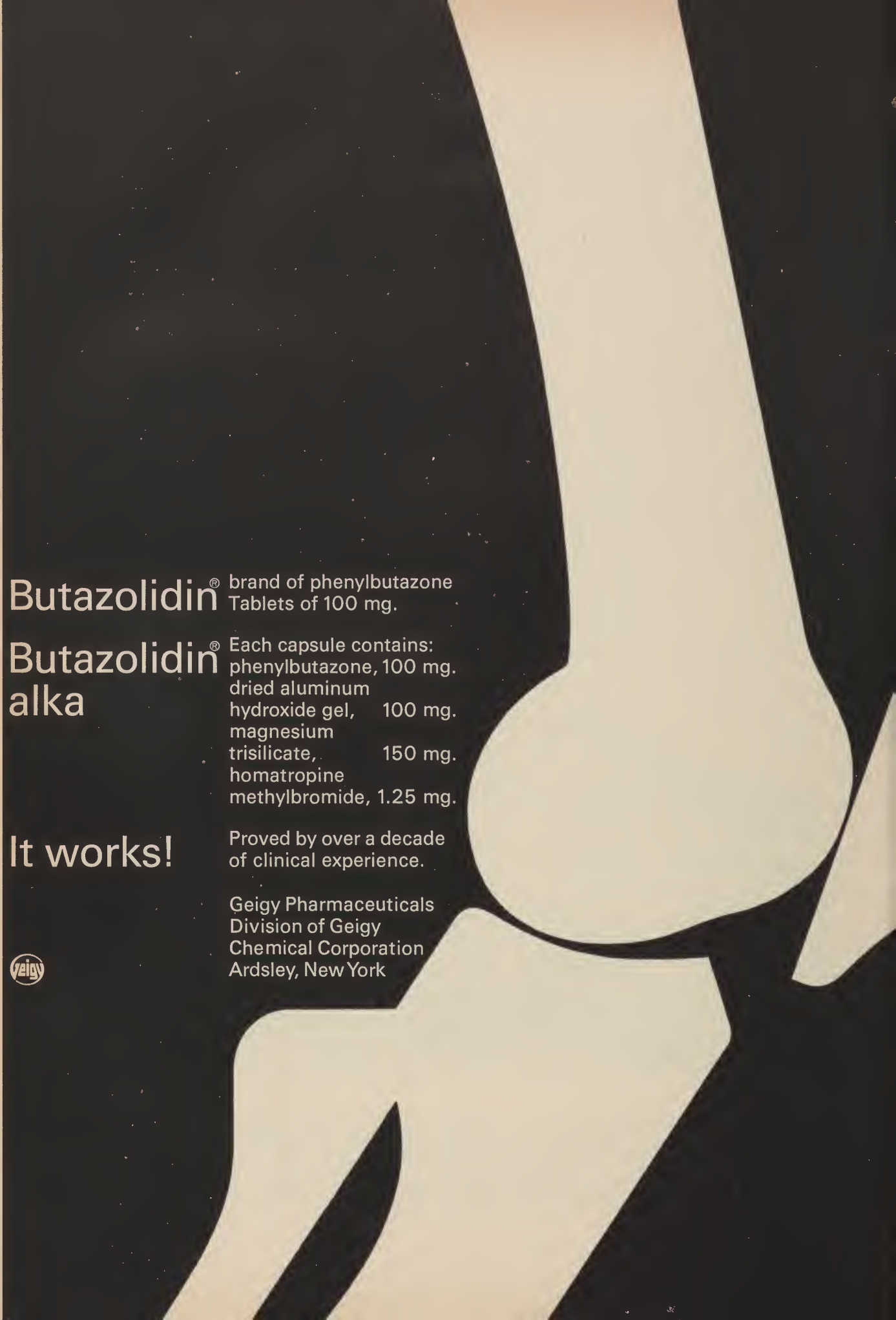
Deprol®

meprobamate 400 mg. + benactyzine hydrochloride 1 mg.

WALLACE LABORATORIES / *Cranbury, N. J.*

CD-3561

Meprobamate—Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses of the drug. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasm, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis, and anaphylaxis. Treatment should be symptomatic and the drug not reinstituted. Isolated cases of agranulocytosis and thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly Fast EEG activity has been reported, usually after excessive meprobamate dosage. Massive overdosage may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse **Dosage:** Usual starting dose, one tablet three or four times daily. May be increased gradually to six tablets daily and reduced gradually to maintenance levels upon establishment of relief Doses above six tablets daily are not recommended even though higher doses have been used by some clinicians to control depression and in chronic psychotic patients. **Supplied:** Light-pink, scored tablets, each containing meprobamate 400 mg. and benactyzine hydrochloride 1 mg. *Before prescribing, consult package circular.*



Butazolidin® brand of phenylbutazone
Tablets of 100 mg.

Butazolidin® alka

Each capsule contains:
phenylbutazone, 100 mg.
dried aluminum hydroxide gel, 100 mg.
magnesium trisilicate, 150 mg.
homatropine methylbromide, 1.25 mg.

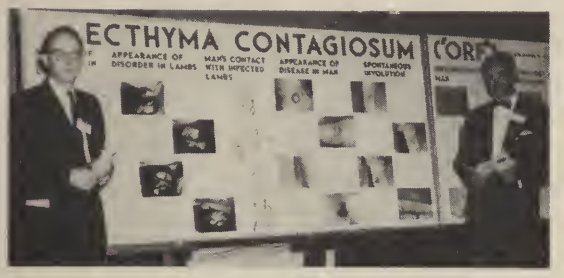
It works!

Proved by over a decade of clinical experience.

Geigy Pharmaceuticals
Division of Geigy
Chemical Corporation
Ardsley, New York

Geigy

MAGOFFIN			
MARTIN			
PERRY	Lyndon F. Combs	.....	.....
	Mary Fox (Alt.)	Present	Present
PIKE	Bill Clark	.....	Present
	B. W. Cassady	Present	Present
	Fifteenth District		
BELL	Charles B. Stacy	Present	Present
	M. J. Evans	.....	.....
CLAY	W. E. Becknell	Present	.....
HARLAN	E. M. Howard	Present	Present
	Philip J. Begley	.....	.....
KNOX	F. X. Sommer	.....	.....
LAUREL	E. C. Seeley	Present	Present
LESLIE			
WHITLEY	Harold B. Barton	Present	Present



Winning scientific exhibit at the Annual Meeting was "Ecthyma Contagiosum" By Ullin W. Leavell, M.D., Michael J. McNamara, and R. J. Muelling, Jr., M.D., all of Lexington. Doctor Leavell is pictured with the exhibit (left) and at the right is Benjamin B. Jackson, M.D., Louisville, chairman of the KMA Scientific Exhibits Committee.

1965 Annual Meeting Dates Set

September 21, 22, and 23 are the dates scheduled for the 1965 Annual Meeting of the Kentucky Medical Association, to be held once again in Louisville.

Headquarters for the meeting will again be the Kentucky Hotel. Scientific sessions and scientific and technical exhibits will be housed at the Convention Center, as was done this fall. Delmas M. Clardy, M.D., Hopkinsville, KMA president, and members of the Council on Scientific Assembly will meet on November 11 to discuss preliminary plans for the 1965 Annual Meeting.

Laboratory at Meeting Tests 215

The clinical laboratory health evaluation test offered for the first time this year at the Annual Meeting was taken by 215 persons, according to Malcolm Barnes, M.D., who was in charge of the project.

Doctor Barnes said 35 pathologists and laboratory personnel from throughout the State worked in the lab during the meeting. The Kentucky Society of Pathologists sponsored the program in cooperation with the Kentucky, Louisville, and Central Societies of Medical Technologists. The limited clinical examination program, offering six blood chemistry determinations, urinalysis, a hemocrit on blood, and a white blood count, will be offered again at the 1965 Annual Meeting.

Delmas M. Clardy, M.D., KMA president, admires the portrait of the late Arch Cole, Ph.D., for many years professor of anatomy at the University of Louisville School of Medicine. The medical school Class of 1953 commissioned the painting and presented it to the school. Doctor Cole died in an automobile accident in 1962.

Dr. Cole Memorialized

S. Randolph Scheen, M.D.*

During the tenth annual reunion of the Class of 1953, University of Louisville School of Medicine, at a meeting during the 1963 Kentucky Medical Association annual session in Lexington, the class voted to commission a painting of our late beloved professor of anatomy, Doctor Arch Cole. Mr. Harry Cronen was commissioned to do the oil portrait, and the painting was presented during the Kentucky Medical Association meeting this year. It will hang alongside the other dignified and beloved scholars and teachers of the University.

Doctor Cole will long be remembered by all of his students. We all considered it an honor to study under him. He was not only a teacher to all of us, but also a friend to whom any of us could turn at anytime for help. Our association with a man such as Doctor Cole will long be remembered in our hearts, and I am sure we are all better physicians for having had his guidance on our way up the medical ladder. This painting will serve to remind us of a man who played a major role in the lives of many physicians.

---

* *Doctor Scheen was chairman of the committee from the Class of 1953 of the U. of L. School of Medicine, who arranged for the painting and its presentation to the school.*

$1000 Club Plaque Unveiled

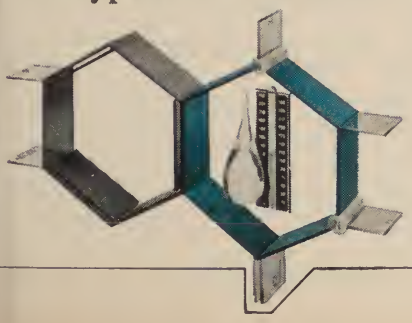
Unveiling of a "$1000 Club Plaque" in the main lobby of the University of Louisville Medical-Dental Research Building took place on Tuesday, September 29, during the KMA Annual Meeting. Speakers included George A. Sehlinger, M.D., president of the Jefferson County Medical Association; Donn L. Smith, M.D., dean of the U of L School of Medicine; and Walter S. Coe, M.D., president of the U of L Medical Alumni Association. Doctor Coe participated in the unveiling along with a representative of the dental profession.

Just turned hypertensive

A 15 mm. Hg drop in diastolic pressure would also suit her very well

For suitably gradual, physiologic hypotensive treatment

HYDROMOX®
QUINETHAZONE·TABLETS
antihypertensive diuretic



HYDROMOX Quinethazone is excellent for use in early hypertension. Extremely well tolerated, the average reported reduction in diastolic pressure is 15 mm. Hg,[1,2] just right for patients with mild to moderate diastolic elevations. Systolic pressure lowered accordingly. A convenient, single daily dose of one to two 50 mg. tablets is usually sufficient.

INDICATED in hypertension with or without edema, and in all types of edema involving salt retention. May be helpful in some cases of lymphedema, idiopathic edema and edema due to venous obstruction.

SIDE EFFECTS: Skin rash (rare), gastrointestinal disturbances, weakness and dizziness, seldom so severe that drug should be stopped. Generally, the adverse effects sometimes associated with the thiazide diuretics are possible. Pre-existing electrolyte abnormalities may be aggravated.

CONTRAINDICATION: Anuria.

1. Steigmann, F., and Griffin, R.: Evaluation of Quinethazone, a New Diuretic. J. Amer. Geriat. Soc. 11:945 (Oct.) 1963.

2. Schwartz, M.: Office Evaluation of a New Diuretic in Patients with Hypertensive Diseases. Scientific Exhibit Presented at the Clinical Meeting of the American Medical Association, Los Angeles, California, Nov. 25-28, 1962.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N.Y.

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David Kinnaird, M.D., Louisville, chairman of Reference Committee No. 5, reports to the House of Delegates at its second meeting on Wednesday, September 30. Vice Speaker George F. Brockman, M.D., Greenville, is at the podium in the background.

House of Delegates Votes on Association Name Change at Annual Meeting; Considers Other Important Resolutions During Busy Sessions

At the 1964 Annual Meeting, the House of Delegates voted to change the constitution so that the name of the Association is now KENTUCKY MEDICAL ASSOCIATION. The word "State" was dropped because many of our suppliers and others confused our Association with state government.

The House accepted recommendations of the 1963-64 President, Geroge P. Archer, M. D., Prestonburg, recommending that Area Hospital Planning be supported by the Association on a voluntary basis only.

The House voted to establish a Judicial Council to handle disciplinary and ethical problems in the future. This group was given broad powers and the only appeal from the KMA Judicial Council will be to the Judicial Council of the American Medical Association.

A mandatory indoctrination program for new members becoming effective January 1, 1965, was adopted. The new members will have a two-year period in which to take the course. The time, place and content are to be approved by the Board of Trustees.

Once more, the House of Delegates went on record opposing the extension of compulsory social security coverage to the self-employed physician.

The Digest of Proceedings of the 1964 KMA House of Delegates Meeting will appear in the December, 1964, Journal of KMA. Completed details on all of the actions of the House will then be printed.

For the second time, the House met on Monday morning and the reference committees met Monday afternoon. The House acted on more than 65 reports of officers, councils, committees, boards, and resolutions. The second meeting was held Wednesday evening, September 30.

Among the six resolutions that were considered by the House, Resolution F, relating to participation in new Third Party Plans, introduced by the Campbell-Kenton County Medical Society, was passed.

Before the coffee break a five-minute address was delivered by Mrs. Bettye Fisher, Evansville, Indiana, past president of the American Association of Medical Assistants. Her talk was very well received.

House members were served coffee during a break in the September 28 meeting by members of the Board of Directors of the Kentucky State Association of Medical Assistants.

COMPARATIVE REGISTRATION FIGURES

KSMA Annual Meetings

	Louisville 1955	Louisville 1956	Louisville 1957	Louisville 1958	Louisville 1959	Louisville 1960	Louisville 1961	Louisville 1962	Lexington 1963	Louisville 1964
KSMA Members	938	923	1094	971	997	1021	996	1014	865	924
Guest Physicians	122	157	178	166	165	203	194	208	141	157
Interns-Residents	106	105	142	108	128	105	102	102	69	108
Medical Students	299	305	328	269	280	289	237	176	59	128
Registered Nurses	55	15	28	22	34	25	31	59	31	34
Exhibitors	174	218	176	211	200	239	204	232	212	297
Guests	121	108	151	164	86	99	132	123	132	125
Technicians—										
Office Assistants	50	54	54	45	63	33	57	71	22	61
TOTAL ATTENDANCE	1865	1885	2151	1956	1953	2014	1953	1985	1531	1844

KMA Records Show All-Time High Membership

Last year at this time it was reported in The Journal that the records of the Kentucky Medical Association membership department showed an all-time high number of active physicians in the state who were active members of KMA and the AMA.

This year another record has been set in membership. Records show total membership of 2,167, as compared to 2,152 last year. Sixty-five counties in Kentucky show 100% KMA membership. In thirty-seven of these counties, all physicians are members of the American Medical Association.

The chart below, which includes membership records as of October 20, will show that an additional number of counties could have 100% membership if one or two physicians became members.

Who are Members of KMA and AMA

(October 20, 1964)

COUNTIES	ACTIVE PHYSICIANS	MEMBERS KMA	MEMBERS AMA
Adair	8	7	6
Allen	5	5	4
Anderson	4	3	1
Ballard	5	5	5
Barren	23	22	21
Bath	4	1	1
Bell	27	21	21
Boone	13	13	12
Bourbon	13	13	6
Boyd	51	49	49
Boyle	21	17	15
Bracken (*) (**)	3	3	3
Breathitt (*) (**)	3	3	3
Breckinridge	6	5	4
Bullitt (5) (**)	5	5	5
Butler (*) (**)	2	2	2
Caldwell	6	5	5
Calloway	15	14	14
Campbell	59	51	48
Carlisle	3	2	2
Carroll	7	6	5
Carter (*)	3	3	2
Casey (*) (**)	4	4	4
Christian	37	27	26
Clark	14	11	9
Clay (*) (**)	6	6	6
Clinton (*) (**)	3	3	3
Crittenden (*) (**)	3	3	3
Cumberland	2	1	1
Davies	67	65	65
Edmonson (*) (**)	2	2	2
Elliott (*) (**)	1	1	1
Estill (*) (**)	4	4	4
Fayette	333	274	243
Fleming (*)	4	4	1
Floyd	17	11	10
Franklin	32	30	28
Fulton (*) (**)	9	9	9
Gallatin	0	0	0
Garrard (*) (**)	3	3	3
Grant (*) (***)	4	4	4
Graves	15	14	14
Grayson (*) (**)	6	6	6
Green (*) (**)	6	6	6
Greenup	9	8	8
Hancock	2	1	0
Hardin	27	25	21
Harlan	38	31	31
Harrison (*)	8	8	5
Hart (*) (**)	5	5	5
Henderson	24	21	21
Henry (*) (**)	5	5	5
Hickman (*)	3	3	2
Hopkins (*)	38	36	35
Jackson (*) (**)	2	2	2
Jefferson	798	724	638
Jessamine (*)	5	5	3
Johnson	12	11	11
Kenton	89	85	82
Knott (*) (**)	3	3	3
Knox	7	6	3
Larue (*)	4	4	2
Laurel (*)	10	10	9
Lawrence	7	6	6
Lee	2	1	1
Leslie	2	0	0
Letcher	14	9	8
Lewis (*)	2	2	1
Lincoln (*) (**)	3	3	3
Livingston (*)	3	0	0
Logan (*) (**)	10	10	10
Lyon	3	2	2
McCracken	61	55	54
McCreary (*) (**)	2	2	2
McLean (*)	4	4	0
Madison (*)	25	25	24
Magoffin (*)	1	1	0
Marion (5) (**)	9	9	9
Marshall (*) (**)	10	10	10
Martin	1	0	0
Mason ()	13	13	10
Meade (*)	3	3	2
Menifee (*) (**)	1	1	1
Mercer	13	12	11
Metcalfe (*) (**)	2	2	2
Monroe (*) (**)	7	7	7
Montgomery	8	6	6
Morgan (*)	4	4	2
Muhlenberg (*)	11	11	10
Nelson	9	8	7
Nicholas (*)	2	2	0
Ohio	8	5	4
Oldham (*) (**)	6	6	6
Owen	3	2	2
Owsley (*) (**)	2	2	2
Pendleton (5)	3	3	1
Perry (*)	16	16	15
Pike	41	24	23
Powell	2	0	0
Pulaski	28	27	26
Robertson	1	0	0
Rockcastle	3	1	0
Rowan	9	6	6
Russell (*)	5	5	4
Scott (*)	8	8	4
Shelby (*) (**)	8	8	8
Simpson	7	4	2
Spencer	5	2	2
Taylor (*)	9	9	7
Todd (*) (**)	3	3	3
Trigg	5	3	3
Trimble (*) (**)	2	2	2
Union (*) (*)	6	5	5
Warren	40	37	36
Washington (*) (**)	5	5	5
Wayne (*)	6	6	5
Webster (*) (**)	7	7	7
Whitley	21	20	19
Wolfe (*) (**)	1	1	1
Woodford	9	6	3
TOTAL	2448	2167	1957

* 100% KMA ** 100% AMA

Note: Report includes teaching staffs at medical schools, physicians i n Public Health, Mental Institutions, T.B. Hospital, VA Hospital, etc.

Health Exam. Survey Set

The Public Health Service's Health Examination Survey will begin October 15 at Barbourville and will be conducted over a period of four weeks. A sample of the child population, ages 6 through 11 years, chosen by a scientific sampling process from Bell, Knox and Whitley Counties, will be examined. This is a continuing project resulting from legislation passed by Congress in 1956.

The purpose of the survey is to collect on a uniform basis statistical information on various aspects of child health and to obtain data on certain physical and physiological measurements of these children. Approximately 200 children will be examined. One such survey has already been conducted in the Louisville area.

Meyer Elected by Nat'l. Druggists

E. Crawford Meyer, Jeffersontown, was elected a vice president of the National Association of Retail Druggists at the association's 66th annual convention in San Francisco. He is a past president of the Kentucky Pharmaceutical Association.

KSAMA Organizes New Chapter

Hardin-Larue County is the most recent chapter of the Kentucky State Association of Medical Assistants, organized at a meeting September 20 at Elizabethtown. Officers of the chapter were installed October 8 by Miss Dorothy Downs, Louisville, KSAMA president.

Continuing Educational Opportunities

From The

KSMA Postgraduate Medical Education Office

IN KENTUCKY

NOVEMBER

11-12	"The Clinical Application of Pulmonary Physiology", University of Kentucky Medical Center, Lexington
12	Pediatrics, "Refresher Course", 8:00 a.m.-5:00 p.m., University of Kentucky Medical Center, Lexington
19	University Surgery Day, 12:00-5:00 p.m., University of Kentucky Medical Center, Lexington
27	"Cardiology Night", 7:30 p.m.-9:00 p.m., University of Kentucky Medical Center, Lexington

DECEMBER

3	"Professor's Day", 9:00 a.m.-3:00 p.m., University of Kentucky Medical Center, Lexington
10	Pediatrics, "Refresher Course", 8:00 a.m.-5:00 p.m., University of Kentucky Medical Center, Lexington
17	University Surgery Day, 12:00-5:00 p.m., University of Kentucky Medical Center, Lexington
17	KMA Joint Trustee District Meeting, 4th, 5th and 7th Districts, Dinner Meeting, Medical Arts Building, Louisville

JANUARY

6, 13 20, 27	"Electrocardiogram Interpretation", 7:00 p.m. to 9:00 p.m., Louisville General Hospital, Louisville
7	"Professor's Day", 9:00 a.m. to 3:00 p.m., University of Kentucky Medical Center, Lexington
14	Pediatrics, "Refresher Course", 8:00 a.m.-5:00 p.m., University of Kentucky Medical Center, Lexington
21	University Surgery Day, 12:00-5:00 p.m., University of Kentucky Medical Center, Lexington
27	"Cardiology Night", 7:30 p.m.-9:00 p.m., University of Kentucky Medical Center, Lexington

IN SURROUNDING STATES

NOVEMBER

16-19	Southern Medical Association, Memphis, Tennessee
20-21	American Psychiatric Association, Bellevue Stratford Hotel, Philadelphia, Pennsylvania
28-29	American College of Chest Physicians, Interim Meeting, Miami Beach, Florida
29	National Conference on Medical Aspects of Sports, AMA, Miami Beach, Fla.
29-Dec. 2	AMA Clinical Meeting, Miami Beach, Florida

DECEMBER

4-5	Association for Research in Nervous & Mental Disease, Roosevelt Hotel, New York
5-10	American Academy of Dermatology, Palmer House, Chicago, Illinois
8	Southern Surgical Association, Boca Raton Hotel, Boca Raton, Florida
9-10	Postgraduate Course in Ophthalmology. The Cleveland Clinic Educational Foundation, Cleveland, Ohio.
9-12	American Academy for Cerebral Palsy, Americana Hotel, New York.

JANUARY

14	Northern Kentucky Seminar, KAGP, Cincinnati, Ohio
25-27	American College of Surgeons, Sectional Meeting, Atlanta Biltmore Hotel, Atlanta, Georgia

FEBRUARY

5-10	Congress on Medical Education, Palmer House, Chicago, Illinois
25-March 2	American Dermatological Association, Boca Raton Hotel, Boca Raton, Florida

Trustees of Wills Eye Hospital Appoint Dr. Keeney

Arthur Hail Keeney, M.D., has been appointed ophthalmologist-in-chief of the Wills Eye Hospital, Philadelphia, the largest institution in the Western hemisphere devoted excusively to diseases of the eye, according to an announcement from the hospital's trustees.

Doctor Keeney

Docotor Keeney, who has served KMA as chairman of the Committee on Highway Safety, will assume his new post after January 1. He will supervise all medical activities in the hospital, including a training program for 21 resident surgeons and research activities of a full-time staff of 40.

A member of the KMA Journal's Board of Consultants on Scientific Articles, Doctor Keeney is also associate professor of ophthamology at the U of L School of Medicine, a charter member f the Kentucky Society for the Prevention of Blindness, and former President of the Kentucky EENT Society.

In 1956, he became the sixty Kentuckian elected to the 100-year-old American Ophthalmological Society and has served that society as a representative to the American Committe on Optics and Visual Physiology. He is the ophthalmic member of the AMA Committee on Medical Aspects of Automotive Safety.

KMA Announces Addition of 13 New Members

Thirteen physicians have recently become new members of the Kentucky Medical Association, according to a recent review of the membership roster. As of October 7, the roles show the addition of the following names:

George C. Cheatham, M.D., and Robert P. Simmons, M.D., Greensburg; H. W. Ford, M.D., and Paul W. Schaper, M.D., Benton; and E. H. Kremer, III, M.D., William L. Miller, and J. Day Shanklin, M.D., all of Louisville.

Other new members are: George C. Barber, M.D., Morehead; Luis E. Davila, M.D., Highland Heights; F. P. Fornaris, M.D., Glasgow; Keith Linville, M.D., Central City; John A. Ritter, M.D., Harlan; and William T. Watkins, M.D., Somerset.

Twelve Kentucky M. D.'s Receive Fellowship in ACS

Twelve Kentucky physicians were among those inducted as new Fellows of the American College of Surgeons during the Clinical Congress of the world's largest organization of surgeons in Chicago, October 5-9.

The Fellowship degree entitles the recipient to use the designation "F. A. C. S." following his name and and is awarded to those who fulfill comprehensive requirements of acceptable medical education and advanced training as specialists in surgery, and who give evidence of good moral character and ethical practice.

Kentucky's new ACS Fellows are: Harry A. Hamilton, Jr., M.D. Corbin; Herbert J. Levin, USA, Fort Knox; Clarence J. McGruder, Jr., M.D., Henderson; John W. Greene, M.D., and Charles H. Nicholson, M.D., Lexington; Milton Comer, M.D., Don L. Harmon, M.D., Burton M. Heine, M.D., William J. Sandman, Jr., M.D., and Charles K. Sergeant, M.D., all of Louisville; Clifton E. Lowry, M.D., and William A. McManus, M.D., Owensboro.

Ky. Surgeons Go To Vietnam

Two Kentucky surgeons, Vernon H. Fitchett, M.D., Madisonville, and Charles C. Kissinger, M.D., Henderson, left recently to go to Vietnam to practice in civilian medical facilities in the war-torn Asian country.

Doctor Kissinger left September 29 to practice in Saigon's largest hospital with a team of three other American physicians. His 30-day volunteer tour of duty is sponsored by CARE. Doctor Fitchett, a neurosurgeon, will spend two years at Da Nang, South Vietnam, under the United States' program of aid being carried out by the Department of Health, Education, and Welfare.

"feels wonderful...cleared head entirely"*

(clearly decongested with Dimetapp)

Dimetapp® Extentabs®

(Dimetane®[brompheniramine maleate], 12 mg.; Phenylephrine hydrochloride 15 mg.; Phenylpropanolamine hydrochloride, 15 mg.)

In sinusitis, colds, U.R.I., Dimetapp lets your "stuffed-up" patients *breathe easy again.* Each long-acting Extentab provides clear relief for up to 10-12 hours, yet seldom causes drowsiness or overstimulation.

BRIEF SUMMARY: ***Indications:*** Dimetapp reduces nasal secretions, congestion, and postnasal drip for symptomatic relief of colds, U.R.I., sinusitis, and rhinitis. ***Side Effects:*** In high dosages, occasional drowsiness due to the antihistamine or CNS stimulation due to the sympathomimetics may be observed. ***Precautions:*** Administer with caution in the presence of cardiac or peripheral vascular diseases and hypertension. ***Contraindications:*** Antihistamine sensitivity. Not recommended for use during pregnancy.

*Clinical report on file, Medical Department, A.H. Robins Co., Inc.

A. H. ROBINS CO., INC., RICHMOND 20, VA.

THE ULCER LIFE

In this "pop art" assemblage, artist Bob Sullivan depicts "the ulcer life" as man-in-a-box. The wall of nails closing in might well symbolize the torturous demands of a rigid, conformist society. As for the man, his disembodied psyche moves relentlessly onward with the blank, fixed stare of a man who has lost control of his own destiny. Small wonder that his gastric mechanism rebels.

NUMBER 1 IN A SERIES

for the ulcer life:
a new strength of glycopyrrolate

ROBINUL® FORTE
2 mg. per tablet

ROBINUL®-PH FORTE
glycopyrrolate 2 mg. phenobarbital 16.2 mg. (warning: may be habit forming)

When glycopyrrolate was first introduced, clinicians were immediately impressed by the remarkable ability of this compound to exert a more specific pharmacologic action on the gastrointestinal tract than on other organ systems. For example, they often found that in difficult patients the dosage could easily be adjusted upwards to achieve the desired suppression of both hypertonicity and secretion . . . without paying the penalty of side effects intolerable to the patient. Thus, it is no surprise that many clinicians suggested that a double-strength 2 mg. tablet of glycopyrrolate would be both practical and useful. For those patients ordinarily unresponsive to anticholinergics or for those exhibiting the more prominent symptoms, the new Forte dosage forms are a worthwhile addition to your ulcer armamentarium.

BRIEF SUMMARY

INDICATIONS: In addition to its primary indications for duodenal and gastric ulcer, glycopyrrolate is indicated for other G-I conditions which may benefit from anticholinergic therapy. Robinul-PH Forte (glycopyrrolate 2 mg. with phenobarbital) is indicated when these situations are complicated by mild anxiety and tension.

CONTRAINDICATIONS: Glaucoma, urinary bladder neck obstruction, pyloric obstruction, stenosis with significant gastric retention, prostatic hypertrophy, duodenal obstruction, cardiospasm (megaesophagus), and achalasia of the esophagus, and in the case of Robinul-PH Forte, sensitivity to phenobarbital.

PRECAUTIONS: Administer with caution in the presence of incipient glaucoma.

SIDE EFFECTS: Dryness of mouth, blurred vision, urinary difficulties, and constipation are rarely troublesome and may generally be controlled by reduction of dosage. Other side effects associated with the use of anticholinergic drugs include tachycardia, palpitation, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, drowsiness, and rash.

DOSAGE: Should be adjusted according to individual patient response. Average and maximum recommended dose is 1 tablet three times a day: in the a.m., early p.m., and at bedtime.

See product literature for full prescribing information.

A. H. ROBINS COMPANY, INC., RICHMOND, VIRGINIA | PHARMACEUTICALS | RESEARCH Robins

MEDICAL SCHOOL NEWS

U.L. Cancer Radiation Center Dedicated October 17

The University of Louisville School of Medicine's new Cancer Radiation Center at Floyd and Walnut Streets, was dedicated in ceremonies October 17 at the Center. Donn L. Smith, M.D., Dean of the medical school, officially accepted the facility.

The center, to be used principally for cancer research and treatment, was financed largely by gifts from the Honorable Order of Kentucky Colonels and the American Cancer Society, and cost around $600,000. Main speaker at the dedication was J.W.J. Carpender, M.D., chief of radiotherapy at the University of Chicago School of Medicine and president of the American Board of Radiology.

Plaque Unveiled

A plaque honoring 169 financial supporters of the University of Louisville School of Medicine's Medical-Dental Research Building was unveiled September 29 in the building's main lobby. Honored were persons who contributed $1,000 or more toward the $3,400,000 unit.

It was announced that grants for medical and dental research received by U. of L. since the opening of the building in April, 1963, new total $3,351,720.

Grants Received

A $10,000 grant to the University of Louisville from the American Cancer Society has been divided by the University research committee to support seven new cancer-research projects and continue another.

The money will go to support studies in the following fields by the researchers named: leukemia, $800—Elton Heaton, M.D., and Giovanni Raccuglia, M.D.; Cancer of the cervix, $900—William L. Miller, M.D.; early stages of leukemia, $1,000—Leonard E. Reisman, M.D.; and characteristics of tumor cells, $700—Thomas G. Scharff, Ph.D.

Other studies, their grants, and the scientists in charge of the research are: possible role of D.N.A. in cancer, $1,487—Frank Swartz, Ph.D.; new equipment for the early detection of throat cancer, $2,154— F. Norman Vickers, M.D.; cancer of the uterus, $650—Paul Young, M.D.; and the continuation of cancer research, $1,680 to Condict Moore, M.D.

A grant of $10,000 from the National Dairy Council for studies of calcium metabolism was recently awarded to Felix Bronner, Ph.D., associate professor of physiology and biophysics.

U.K. Researchers Get Grants For Smoking-Effects Study

Two University of Kentucky Medical faculty members, Jerome E. Cohn, M.D., and E. Douglas Rees, M.D., both of the department of medicine, have received grants from the American Medical Association Education and Research Foundation to study different phases of the effect of tobacco smoking on health.

Doctor Cohn, who received a grant of $70,790, will study the effect of smoking on the lungs. Doctor Rees received $21,660 to investigate the effect of certain cigarette particles on chromosomes.

In a separate grant, the Milbank Memorial Fund of New York City has awarded a $10,000 grant to the Medical Center for support of a new residency program in community medicine. Kurt W. Deuschle, M.D., chairman of the department, will coordinate the program.

The U.S. Department of Health, Education and Welfare, Division of Health Research Facilities, has announced the award of a $125,000 grant to the Medical Center to assist in the construction of an off-campus animal facility.

Faculty Changes and Appointments

The University of Kentucky Board of Trustees have recently approved the following Medical Center faculty appointments and changes:

Appointments: Billie M. Ables, Ph.D., attending in clinical psychology in the department of psychiatry; David Bruce, M.D., instructor, and James R. Collins, M.D., instructor, both in the department of anesthesiology; Robert N. McLeod, Jr., M.D., assistant professor, department of pediatrics; and William Norton, M.D., physician in the University Health Service and assistant professor of medicine.

Other new appointments are: David Peck, Ph.D., instructor in anatomy; Keene A. Watson, M.D., assistant professor of community medicine; and James F. Zolman, Ph.D., assistant professor of physiology and biophysics.

The following changes were announced later: Ralph Shabetai, M.D., associate professor of medicine; Carl H. Fortune, M.D., clinical professor of medicine; Abdel Rahim, M.D., associate clinical professor of community medicine, and Stanley L. Block, M.D., associate clinical professor of psychiatry.

EENT Society Elects Officers

Alvin C. Poweleit, M.D., Covington, was installed as president of the Kentucky Eye, Ear, Nose and Throat Society at a meeting held in conjunction with the KMA Annual Meeting on October 1. Other officers are Roy Martin, M.D., Louisville, president-elect; and Edward C. Shrader, M.D., Louisville, secretary-treasurer. Following scientific sessions at the Convention Center, the group had a dinner and social hour at Stouffers.

Dr. Chumley Re-Elected

Jack L. Chumley, M.D., Louisville, was re-elected president of the Heart Association of Louisville and Jefferson County at the October 15 meeting of the Association at the Brown Hotel. Doctor Chumley, who is Scientific Editor of The Journal of KMA, is a clinical associate in medicine at the University of Louisville School of Medicine.

Chest Physicians Choose Gordon

Newly elected officers of the Kentucky Chapter, merican College of Chest Physicians are Armond ordon, M.D., Louisville, president; Porter Mayo, D., Lexington, vice president; and Alex Saliba, D., Hazlewood, secretary-treasurer. They were cted during the KMA Annual Meeting on Sptember . Their scientific sessions were held jointly with Kentucky Thoracic Society and were followed by ocial hour and dinner at the Kentucky Hotel. entific

AMA Appoints Panel of Nurses

The American Medical Association has announced appointment of an ad hoc panel of professional rse consultants to serve as advisors to AMA's Comttee on Nursing.

The panel, which held its first meeting October 16 Philadelphia, will inform the Committee of recent nds in nursing education and service and offer vice on future programming. In turn, the Committ will acquaint the panel with AMA programs and ivities in the nursing area. The formation of the nel demonstrates the intent of the medical profesn to work closely with its nursing colleagues tord the ultimate goal of optimal patient care.

Medical Assistants Hold Workshop

The Kentucky State Association of Medical Assistas held its first membership extension Workshop at xington on October 4 according to Miss Dorothy wns, Louisville, KSAMA president.

Members from the ten counties represented were lcomed to the meeting by Andrew M. Moore, M.D., sident of the Fayette County Medical Society. Also the program were Nathaniel L. Bosworth, M.D., xington, and Jack L. Chumley, M.D., Louisville, irman of the KSAMA Advisory Board. A variety medical and related topics were presented during one-day session.

Pertinent Paragraphs

he American Medical Association will sponsor a Con-nce on Blood and Blood Banking December 11-12 the Drake Hotel in Chicago, announced Gunnar ndersen, M.D., chairman of the AMA Committee Blood. Further information on the Conference, ch is directed toward the practicing physician, may obtained from the Department of Environmental alth, American Medical Association, 535 North rborn St., Chicago, Ill.

Winners of the 1965 essay contest of the American lege of Chest Physicians will receive cash awards he amounts of $500, $300, and $200, for the best ys prepared by undergraduate medical students on phase of the diagnosis and/or treatment of chest ases. Additional information may be obtained by ing Mr. Murray Kornfeld, Executive Director, CP, 112 E. Chestnut Street, Chicago, Ill. 60611.

KMA Annual Meeting Guests Express Appreciation

"Just a note to tell you how much I appreciated the invitation to join you at lunch and for some of the meeting of the Kentucky State Medical Association. The luncheon was an enjoyable occasion, and I want to congratulate you upon a most well organized meeting.

Thanks for asking me."

R. H. Kampmeier, M.D., President,
Tennessee Medical Association

"I certainly enjoyed my stay in Louisville and wish to express my appreciation and thanks for your courtesy and hospitality."

George J. Hamwi, M.D., Professor of Medicine,
Ohio State University College of Medicine

"I thoroughly enjoyed my visit to Louisville and the opportunity to participate in your 1964 Annual Meeting. Please convey to the officers of KMA and particularly to your headquarters staff my appreciation for the warm hospitality that was accorded me and the many little things that were done to make my stay so pleasant."

Leon J. Warshaw, M.D.
New York, New York

"It was a very great pleasure to meet with the group in Louisville. I enjoyed both the scientific and the social affairs tremendously . . . . . Most of all I appreciated the excellent organization of your meetings, which is indeed a great boon to the speakers . ."

Elsie R. Carrington, M.D.,
Research Professor of Obstetrics and Gynecology
Women's Medical College of Pennsylvania

"Everyone was most courteous and I did enjoy myself very much . . ."

Kenneth R. Byerly, Associate Professor of
Journalism, University of North Carolina

"I enjoyed appearing before the Kentucky State Medical Association in Louisville . . . . . Please accept my sincere thanks for the many kindnesses extended to me."

Noble O. Fowler, M.D., Professor of Medicine,
University of Cincinnati College of Medicine

"I enjoyed very much my visit with your group in Louisville . . . . . and I appreciated the honor of having a small part in your program."

H. R. McCarroll, M.D., Associate Professor of
Orthopaedic Surgery, Washington University
School of Medicine

"You and your staff were most hospitable during the Annual Meeting in Louisville . . . . . all arrangements, before and during the Meeting, were most satisfactory."

Thomas E. Shaffer, M.D., Professor of Pediatrics,
Ohio State University College of Medicine

"I should like, at this time, to express my thanks to the Council on Scientific Assembly for their fine hospitality."

D. Emerick Szilagyi, M.D., Henry Ford Hospital,
Detroit, Michigan

"It was a real pleasure having the opportunity to attend the Kentucky State Medical Association Annual Meeting, and to speak to the General Session. I also enjoyed talking to the anesthesiology group in the afternoon."

C. R. Stephen, M.D., Professor of Anesthesiology
Duke University Medical Center

"I appreciated very much the opportunity to be with the Kentucky State Medical Association in Louisville, and I want to thank you for your hospitality."

Trawick H. Stubbs, M.D., Director,
Community Mental Health Service,
State of Georgia Department of Public Health

STATEMENT OF OWNERSHIP, MANAGEMENT AND CIRCULATION

(As of October 23, 1962; Section 4369, Title 39, United States Code)

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2. Title of Publication: THE JOURNAL OF THE KENTUCY MEDICAL ASSOCIATION.

3.. Frequency of issue: Monthly

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7. Owner: Kentucky Medical Association, 3532 Janet Avenue, Louisville, Ky., 40205; President, Delmas M. Clardy, M.D., 901½ E. Main St., Hopkinsville, Ky., 42240; Secretary, Henry B. Asman, M.D., Medical Arts Building, Louisville, Ky. 40217; Treasurer Keith P. Smith, M.D., Corbin, Ky., 40701.

8. Known bondholders, mortgagees and other security holders owning or holding 1% or more of total amount of bonds, mortgages or other securities: None.

9. Paragraphs 7 and 8 include, incases where the stockholder or security holder appears upon the books of the company as trustee or in any other diduciary relation, the name of the person or corporation for whom such trustee is acting, also the statements in the two paragraphs show the affiant's full knowledge and belief as to the circumstances and conditions under which stockholders and security holders who do not appear upon the books of the company as trustees, hold stock and securities in a capacity other than that of a bona fide owner. Names and addresses of individuals who are stockholders of a corporation which itself is a stockholder or holder of bonds, mortgages or other securities of the publishing corporation have been included in paragraphs 7 and 8 when the interests of such individuals are equivalent to 1% or more of the total amount of the stock or securities of the publishing corporation.

10.

	Average No. copies each issue during Preceding 12 months	Single issue Nearest Filing Date
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1. To term subscribers by mail, carrier delivery or other means	2,895	2,413
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C. Free distribution (including samples) by mail, carrier delivery, or by other means	238	238
D. Total no. of copies distributed (Sum of lines B1, B2, and C)	2,721	2,721

I certify that the statements made by me above are correct and complete.

J. P. Sanford, Managing Editor

Dr. Hurt Heads Orthopedic Soc.

New president of the Kentucky Orthopedic Society is O. James Hurt, M.D., Louisville. Doctor Hurt was elected at the society meeting held on September 30 as an adjunct to the KMA Annual Meeting. Also elected at that time were Eugene Power, M.D., Lexington, vice president; and Wayne W. Kotcamp, M.D., Louisville, secretary-treasurer. Guest speaker at the scientific sessions was H. Relton McCarroll, M.D., St. Louis, Mo.

Dr. Gumbert Elected by Pilots

George M. Gumbert, Jr., M.D., Lexington, was elected president of the Flying Physicians Association at the association's annual meeting at Palm Springs, Sept. 27-Oct. 2. He will serve for one year. Membership in the association is open to licensed physicians who are members of medical societies approved by the board and who hold valid pilot's certificates. There are 22 members from Kentucky.

* * *

Liver Biopsy

Continued from Page 859

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* * *

Management of Occiput Posterior

Continued from Page 861

whom the key-in-lock maneuver was carried out.

Summary

In one thousand consecutive private patient deliveries, a previously described method of manual rotation of the posterior occiput was employed. This method was effective in 69.1 per cent of the occiput posteriors encountered.

Counter pressure at the cornua of the uterus diagonally opposite the occiput was found to greatly facilitate the maneuver.

After 92 rotations by this method, 52 per cent were allowed to deliver spontaneously.

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Dr. Hernandez Elected

C. E. Hernandez, M.D., Elizabethtown, was elected president of the Kentucky Association of Public Health Physicians at the September 29 meeting held in Louisville in conjunction with the Kentucky Medical Association's Annual Meeting.

Serving with Doctor Hernandez during the coming year will be Logan R. Campbell, M.D., Danville, president-elect; Astra U. Kidd, M.D., Brownsville, vice-president; and Mary Pauline Fox, M.D., Hazard, secretary-treasurer.

Correction

It was inadvertantly stated in the October issue of The Journal of KMA that John L. Murphy, former advertising director of the AMA and now employed by the State Medical Journal Advertising Bureau, has succeeded Alfred J. Jackson, retired. Mr. Jackson had served as president of the Bureau for many years and was succeeded by Frank L. Ramsey, M.D., Indianapolis.

Mr. Murphy is a layman (and not an M.D., as indicated in the October item) and is director of the Bureau's sales and promotion activities in the New York office of the Bureau.

Preleukemia

Continued from Page 864

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Continued from Page 867

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CASE STUDIES IN OBSTETRICS AND GYNECOLOGY: by F. Jackson Stoddard, M.D.; Published by W. B. Saunders Company, Philadelphia, 1964; 312 Pages; Price, $8.50.

This fine contribution by Doctor Stoddard gives the student valuable working knowledge of the speciality of Obstetrics and Gynecology. This book, as stated in its preface, is designed to compliment and make more meaningful formal training and experience in Obstetrics and Gynecology. The case study method of instruction has proved itself repeatedly in medical school teaching. By giving individual case presentation together with discussion of them, ability to handle clinical problems is furthered.

Regimen of the management of the important complications are presented. Practically all the major problems encountered in Obstetrics and Gynecology are given in this fine presentation. I heartily recommend it to both the student and the practitioner.

JOHN W. GREENE, JR., M.D.

FUNDAMENTALS OF OTOLARYNGOLOGY, Fourth Edition: by A. R. Boies, M.D., J. A. Hilger, M.D., and R. E. Priest, M.D.; Published by W. B. Saunders Company, Philadelphia, 1964; 553 Pages; Price, $8.50.

The Preface of this book states that it is designed "to offer fundamental information to the undergraduate medical student or to the physician who is not a specialist in otolaryngology." With the recent advances in otolaryngology, this goal is difficult.

The book is unusually complete, in that most areas of modern otolaryngology have been properly recognized. This represents a major accomplishment in a text of this size.

The organization of the fourth edition is similar to that of the third. However, areas that were briefly discussed in the previous edition have been expanded and clarified.

The approach to each section is ideal, as it reviews the basic sciences as they relate to clinical situations. Pathologic states are then discussed individually from the etiology to various forms of treatment. The book reads easily, and the principles set forth are both basic and sound. The numerous drawings and illustrations enhance the often difficult relationships in question.

I believe the authors have done a fine job in presenting a basic text for the non-specialist.

GERALD D. LANDAU, M.D.

THE SPECIALTIES IN GENERAL PRACTICE, Third Edition; edited by Russell L. Cecil, M.D., and Howard F. Conn, M.D.; Published by W. B. Saunders Company, Philadelphia, 1964; 676 pages; Price, $17.50.

The vast expansion of medical knowledge has put heavy demands on the general practitioner's reading time. Only a few books are of sufficient practical value to merit his constant usage. *The Specialties in General Practice* has gained this distinction and comes as close to being a textbook of general practice as any published in this country to date.

As well known as this volume is, only a few general physicians are unfamiliar with it. Eighteen authorities have contributed component chapters which have been blended into a consistent and readible text. This is not primarily a do-it-yourself atlas: it is a review of cogent factors in the recognition and management of those diseases most frequently encountered in family medicine. That pedantic tic—to allot much space to rare conditions—is well restrained. The use of tables and illustrations is likewise limited to essential and useful topics.

To attempt to encompass such a broad field as general practice in a single book is an ambitious, if not impossible undertaking. But the reader will be astonished by one omission of the editors, one of whom is a professor of medicine and textbook author; viz., there is no chapter on common medical conditions. Despite the high value of the other portions, the busy practitioner who spends much time with ulcer, hypertensive and coronary patients will consider this a significant oversight. Further, a section of the use of the xray in diagnosis would be welcome since this is an indispensable tool in daily practice. Two chapters list essential equipment necessary for that specific field which suggests another avenue for improvement.

The name implies that only general practitioners will profit from a continuing awareness of current management of patients in all fields of medicine. Since patients' problems are seldom restricted to one specialty, however, the book will be of value to all doctors interested in remaining the "compleat physician".

HOMER B. MARTIN, M.D.

fter Surgery: B and C vitamins are therapy

Therapeutic amounts of B and C in stress formula vitamins often are vital during periods of physiologic stress. STRESSCAPS, designed to meet increased metabolic demands, aids in achieving a more comfortable convalescence, a more rapid recovery. After surgery, as in many stress conditions, STRESSCAPS vitamins are therapy.

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Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100; bottles of 500.

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In Memoriam

WILLIAM F. O'DONNELL, JR., M.D.
Hazard, Ky.
1918 - 1964

William F. O'Donnell, Jr., M.D., a general surgeon and general practitioner in Hazard for 18 years, died September 24 of an apparent heart attack. A native of Richmond and a 1942 graduate of the University of Louisville School of Medicine, Doctor O'Donnell had practiced in Hazard since his release from the U.S. Army Medical Corps in 1946.

J. EDMUNDO ESTEVES, M.D.
Warsaw, Ky.
1924 - 1964

J. Edmundo Esteves, M.D., 40, Warsaw general practitioner, was killed in a September 20 automobile accident in Cincinnati. Doctor Esteves, a native of Ecuador, was his country's honorary vice-consul in the Cincinnati area. He was a 1952 graduate of the Central University Faculty of Medicine in Quito, Ecuador and had practiced on a limited license in Warsaw for three years.

JOHN PORTER WALTON, M.D.
Central City, Ky.
1882 - 1964

John P. Walton, M.D., 82, who was named Outstanding General Practitioner of the year in 1962 by the Kentucky Medical Association, and Central City's Man of the Year in 1957, died September 21 in Greenville after a long illness. Doctor Walton, who had practiced in Muhlenberg County for 55 years, graduated in 1906 from the Hospital College of Medicine in Louisville. He had retired last year.

CHARLTON A. MACPHERSON, M.D.
Louisville, Ky.
1889 - 1964

Charlton A. Macpherson, M.D., 75, who had lived in Louisville since his retirement from practice in 1954, died September 3 in Louisville. He had practiced general medicine and surgery at St. Clair, Mich. for 30 years before his retirement. Doctor Macpherson was a 1912 graduate of the University of Toronto Faculty of Medicine, Toronto, Ontario, Canada. He was a native of Ontario.

MARSHALL M. JONES, M.D.
Lexington, Ky.
1915 - 1964

Marshall M. Jones, M.D., 48, Lexington general practitioner for 20 years, died October 6 following a long illness. Doctor Jones, a 1941 graduate of Howard University School of Medicine, Washington, D.C., was a Lieutenant Colonel in the Army Reserve and a veteran of World War II. For the past three years he had served as a City physician for the city of Lexington.

ALBRO L. PARSONS, M.D.
Louisville, Ky.
1882 - 1964

Colonel Albro L. Parsons, 81, a former medical officer in the U.S. Army, died September 3 in Louisville. Colonel Parsons, a native of Louisville and a 1904 graduate of the old Louisville Medical College, practiced and taught medicine in Louisville for 12 years before becoming a medical officer. He had been retired for a number of years.

WILLIAM THOMAS JESSEE, M.D.
Plummer's Landing, Ky.
1877 - 1964

William T. Jessee, M.D., 86, who had practiced medicine in Fleming County for 50 years, died at his home at Plummer's Landing September 5 after a heart attack. Doctor Jessee, who graduated in 1902 from the Eclectic College of Medicine in Cincinnati, practiced in Rome and Portsmouth, O., and in Lewis County, Ky., before going to Fleming County. He retired from active practice in 1957.

ALVA GLENN BARTON, M.D.
Louisville, Ky.
1925 - 1964

A. Glenn Barton, Jr., M.D., 39, died September 27 at his home in Jeffersonville, Ind. Doctor Barton, a general practitioner, was graduated in 1960 from the University of Louisville School of Medicine. A native of Memphis, Tenn., he was a veteran of World War II.

KENTUCY MEDICAL ASSOCIATION

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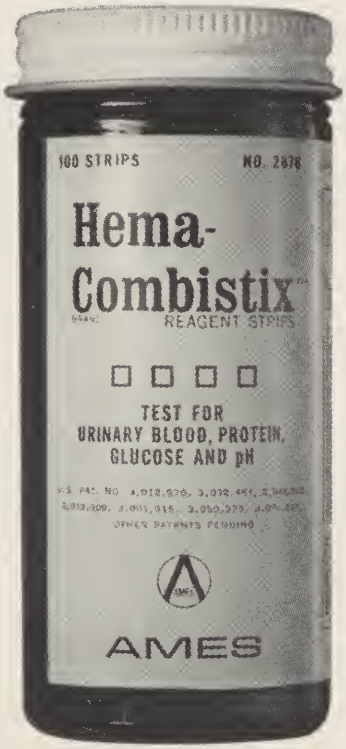
JOURNAL OF THE KMA BUYERS GUIDE FOR NOVEMBER, 1964



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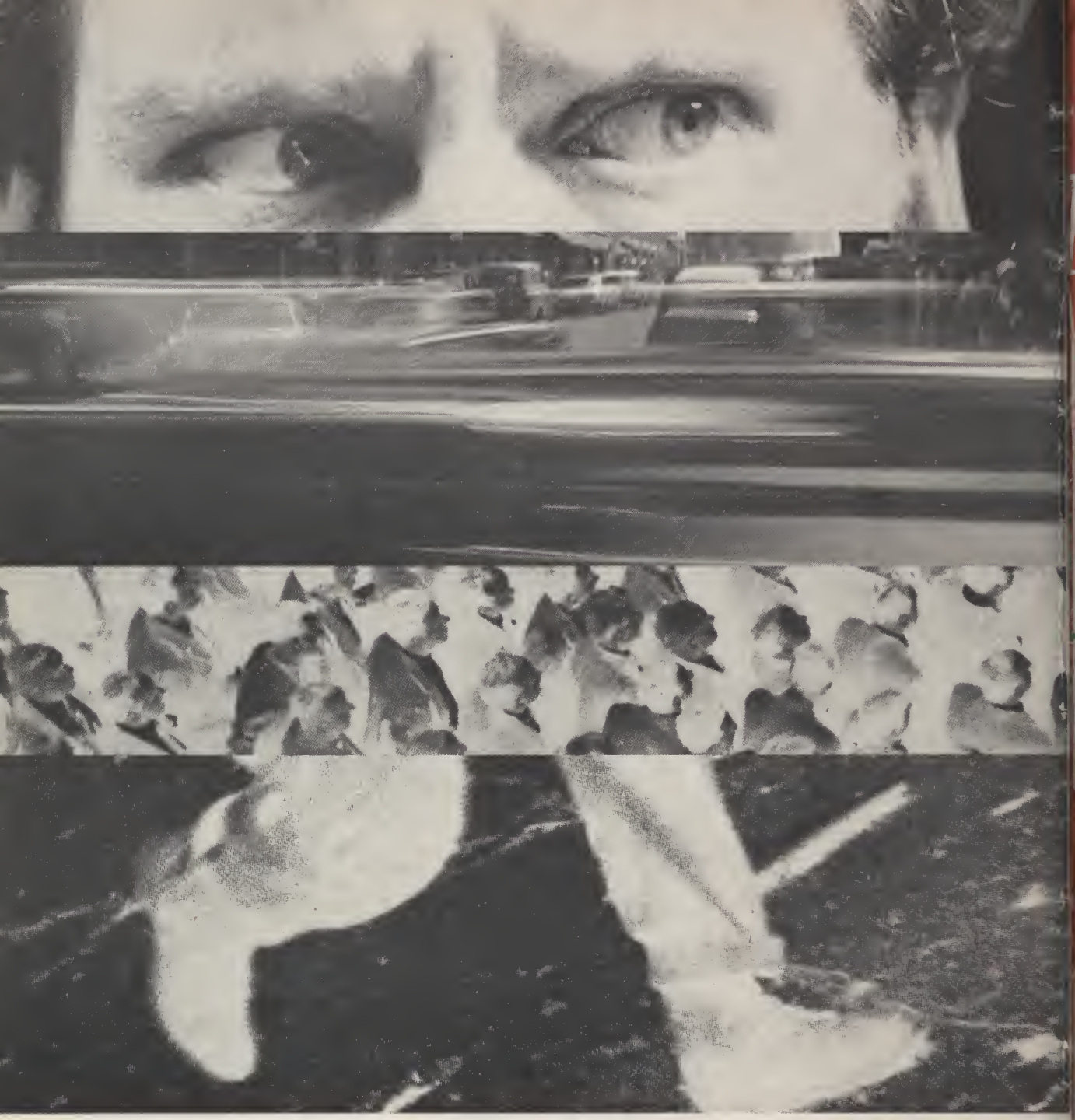

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Cautions—Occasional side effects, often dose-related, are drowsiness, ataxia, minor skin rashes, menstrual irregularities, nausea and constipation. Paradoxical reactions may occasionally occur in psychiatric patients. Individual maintenance dosages should be determined. Advise patients against possibly hazardous procedures until maintenance dosage is established. Though compatible with most drugs, use care in combining with other psychotropics, particularly MAO inhibitors or phenothiazines; warn patients of possible combined effects with alcohol. Observe usual precautions in impaired renal or hepatic function, and in long-term treatment.

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DECEMBER 1964 • VOLUME 62 • NUMBER 12

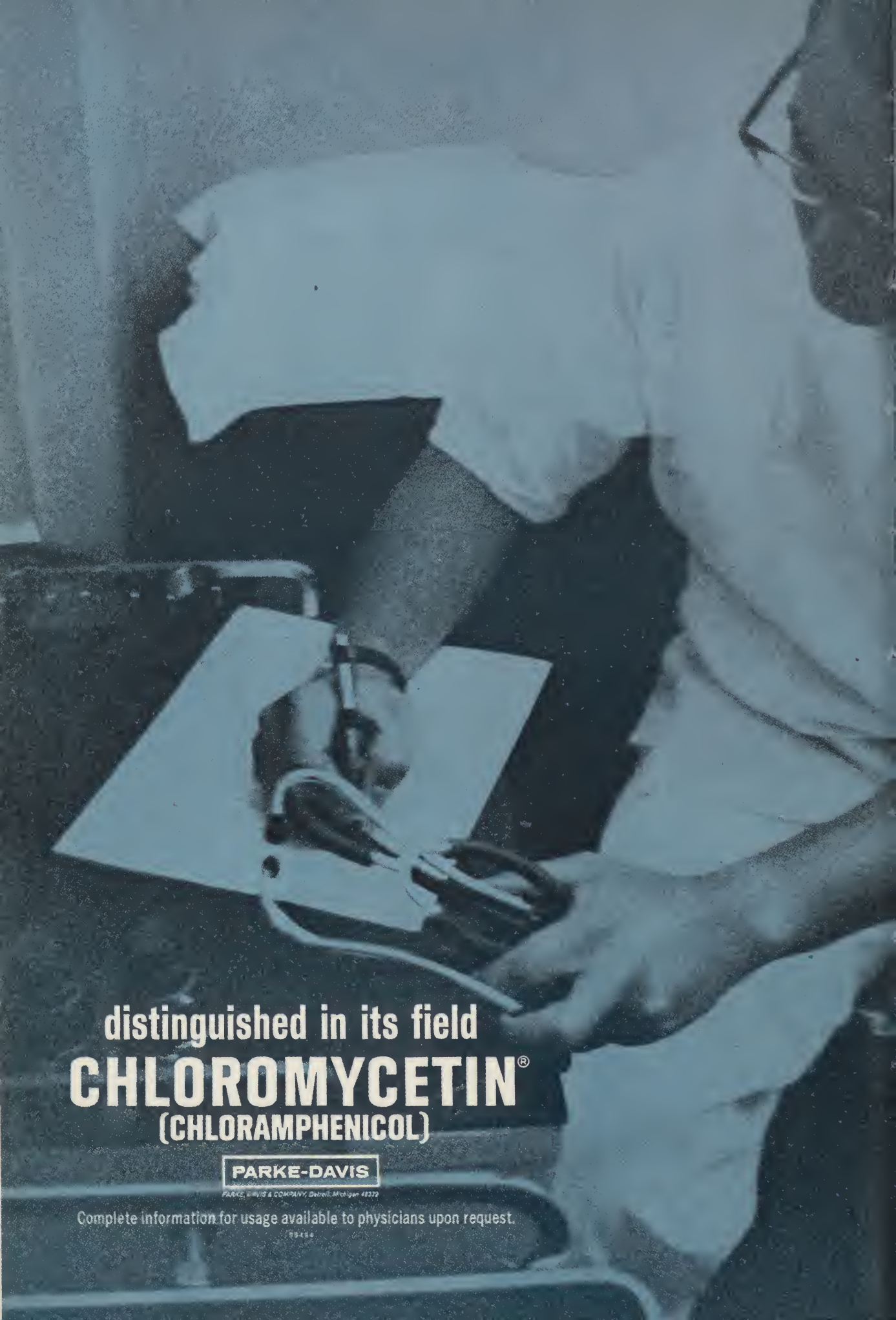
Season's Greetings

THE JOURNAL

OF THE KENTUCKY MEDICAL ASSOCIATION

In This Issue

KMA 1965 Interim Meeting — March 18
Gabe's Restaurant, Owensboro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VOLUME 62 • DECEMBER 1964

JOURNAL of the KENTUCKY MEDICAL ASSOCIATION

Contents

Published: 3532 Janet Avenue, Louisville, Ky. 40205

Subscription $8.00—single copy .80

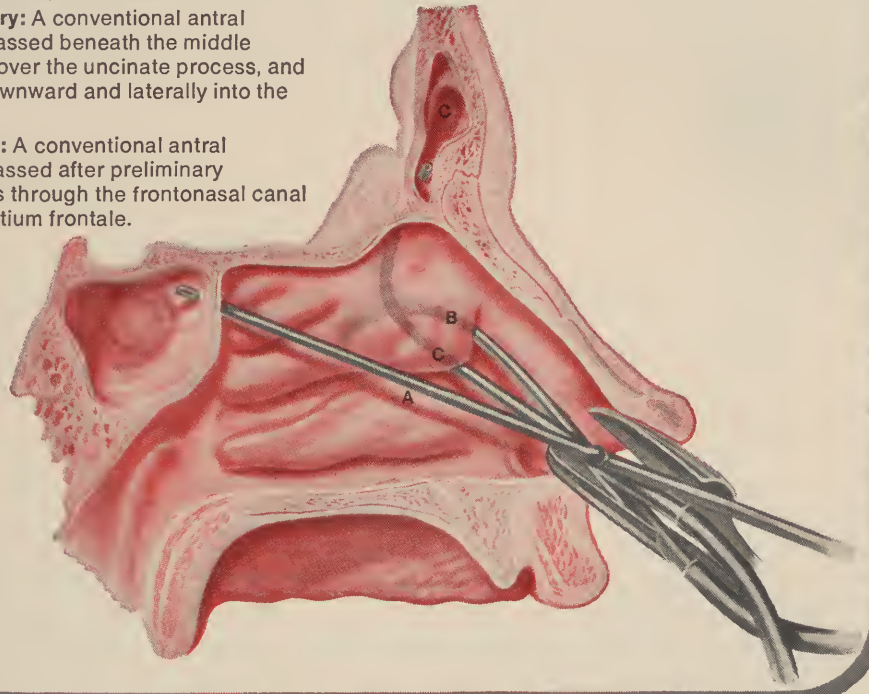
Second-class postage paid at Louisville, Kentucky. Acceptance for mailing at special rates postage provided in Section 1103, act of Oct. 3, 1917, authorized May 25, 1920.

A rhinologic approach to the sinuses
Sagittal anatomical section of nasal cavity showing approach for probing or irrigation by cannulas.

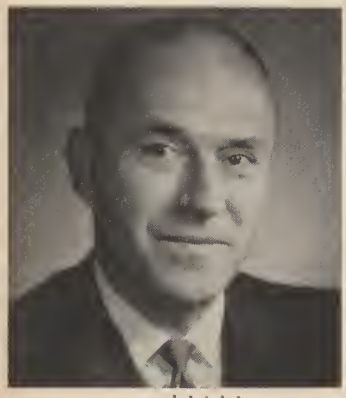
A—Sphenoid: A sphenoid cannula (under 13.5 cm.) passed around the middle and superior turbinates to the anterior wall of the sinus through its ostium.

B—Maxillary: A conventional antral cannula passed beneath the middle turbinate, over the uncinate process, and rotated downward and laterally into the ostium.

C—Frontal: A conventional antral cannula passed after preliminary maneuvers through the frontonasal canal into the ostium frontale.



MESSAGE FROM THE PRESIDENT



What Is Your Motivation?

AS the Christmas Season approaches "Peace on Earth and Good Will toward Men" will be used with increasing frequency. This quotation, translated into love for your fellow-man, can be the motivation for vocations in life. This season is an excellent time for self-appraisal, not in a critical manner, but an honest inquiry of why you are a physician.

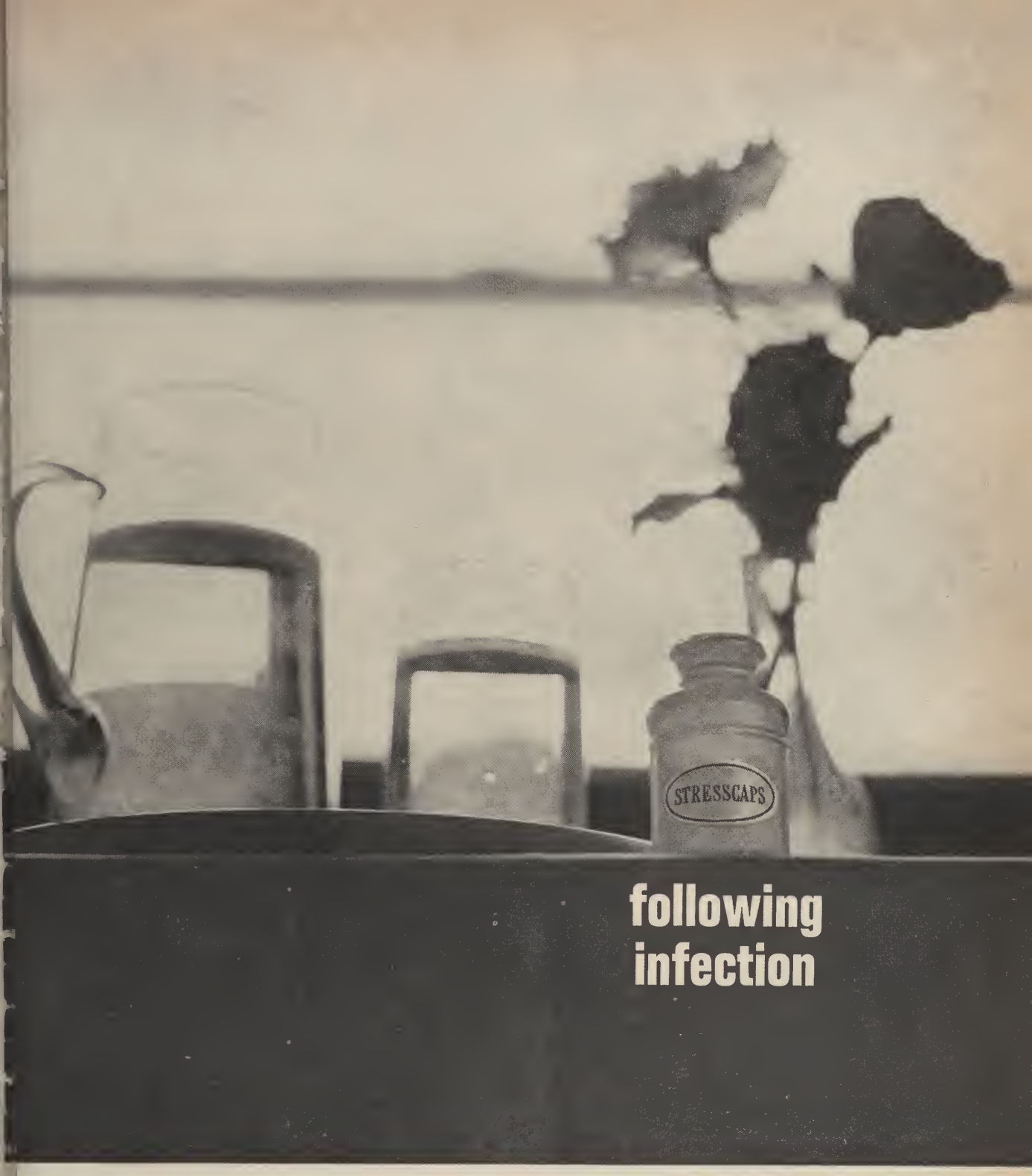
A desire to be of service to others is the motivation of everyone living in dignity. Healing is the desire for the physician; truth for the scientific researcher; beauty for the artist, education for the dedicated teacher; religion for the minister. The list is endless. The bond that unites these vocations to the individual is the unselfish, altruistic character and noble desire to give something, which, in the final analysis, is love. Without this desire, life would be lacking in meaning, purpose and joy of living.

Other motivations may begin as desires for prestige, fame, social status and fortune. Many become physicians because of one or more of these factors, but whatever the force that originally drove us to cross the threshold of the Temple of Aesculapius to follow the code of Hippocrates, the vocation of love of services to our fellow-man most often prevailed. What started as selfish desires ended in true dedication.

Despite the poisonous criticisms that have been aimed at physicians throughout the ages, medicine is still the only profession nourished by the dream of service and creation—serving the sick and creating health. Each physician has a dream as characteristic and identifying as his own fingerprints—of what, for him, is the best way of being a doctor and fulfilling with dignity and greatness the task of his profession.

Medicine is truly the great vocation. It exemplifies always "Peace on Earth and Good Will toward Men." May it never be otherwise.

Delman M. Cleary



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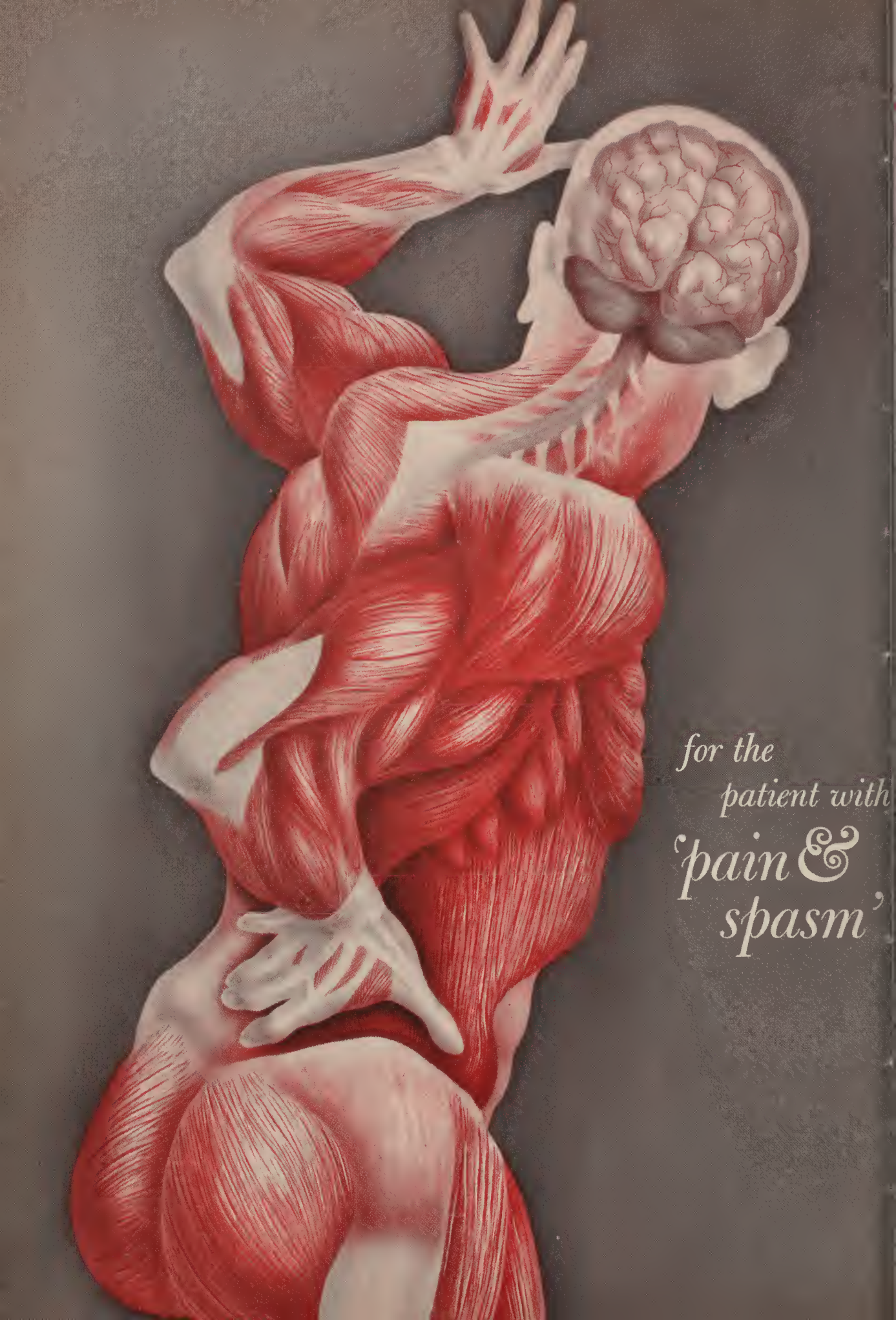
for the
patient with
'pain &
spasm'

ain is almost invariably a presenting symptom in cases of skeletal muscle **spasm**

In some instances, the pain subsides on relaxation of the muscles in spasm. In others, relaxant therapy alone fails to give adequate relief, and supplementary analgesia (and possibly sedation) are indispensable, as in cases of:

provocative pain, when muscle spasm is triggered by some painful underlying musculoskeletal defect.

residual pain, when relaxation of severe spasticity leaves a degree of myalgia that tends to reinvoke spasm.

severe pain, when the degree of pain is such as to cause persistence of symptoms in spite of relaxant therapy.

emotionally aggravated pain, when anxiety or agitation creates tension that thwarts the efficacy of both relaxant and analgesic medication.

In such cases, ROBAXISAL and ROBAXISAL-PH have proven highly effective in assuring decisive and comprehensive relief. The ROBAXISAL formula—of ROBAXIN (methocarbamol), the potent muscle relaxant, together with aspirin, the time-tested and proved analgesic—produces higher plasma salicylate levels than equivalent doses of aspirin alone, and serves effectively to control both spasm and pain. ROBAXISAL-PH's combination of ROBAXIN (methocarbamol) with the analgesic-sedative ingredients of the PHENAPHEN formula—including phenobarbital—helps additionally to ease apprehension.

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"PAIN & SPASM"
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ROBAXISAL and ROBAXISAL-PH are indicated in strains and sprains, painful disorders of the back, "whiplash" injury, myositis, pain and spasm associated with arthritis, torticollis, and headache associated with muscular tension.

Side effects such as lightheadedness, slight drowsiness, dizziness and nausea may occur rarely in patients with intolerance to drugs, but they usually disappear on reduction of dosage.

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THE INSURANCE PAGE

Five Important Years

FIVE YEARS AGO, the Editor and his Advisory Committee of The Journal of the Kentucky Medical Association instituted a new editorial feature, devoted to information concerning voluntary health insurance and prepayment. It has been our privilege to serve as the first editor of the Insurance Page.

This has been a task which we have enjoyed, since it is our conviction that the financing of health care through voluntary prepayment is a sine qua non in the preservation of our present system of medical practice in this country. It is most important, therefore, that all of our physicians be well informed concerning the various types of health insurance available to their patients.

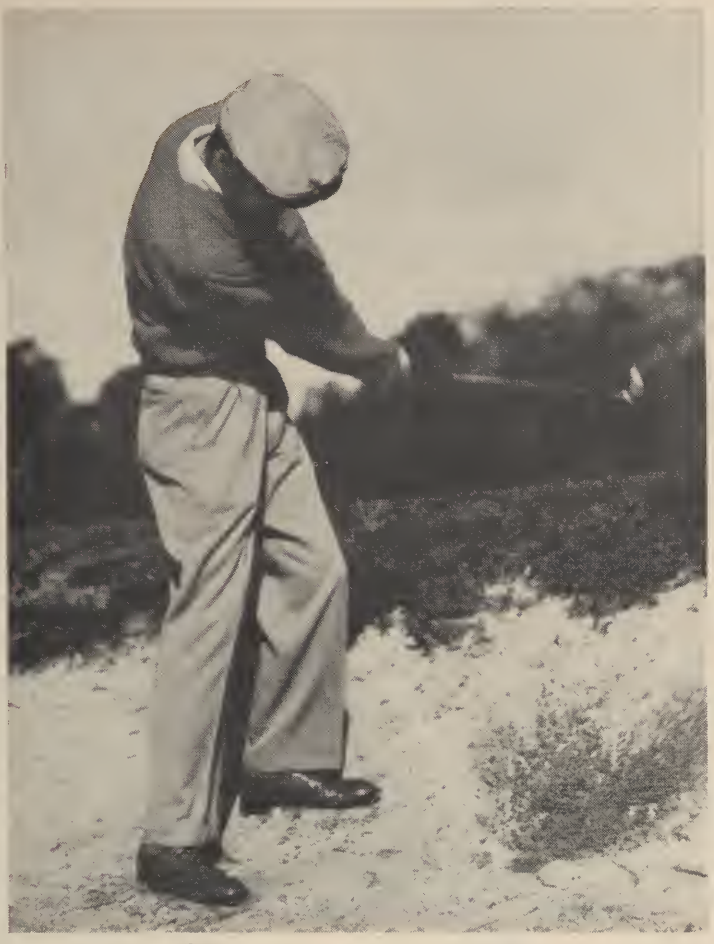
The time has come when we feel that it is advisable for us to relinquish the duties of this editorship to someone else. We are happy to know that the editors of The Journal have selected William W. Hall, M.D., of Owensboro, for this position.

Doctor Hall is deeply devoted to the philosophy of voluntary prepayment as the best means of financing health care for most of our people, and he is very knowledgeable in this area. Under his guidance the Insurance Page will become an increasingly valuable source of information for our Kentucky physicians.

To the editors of The Journal, who have been so kind to us; to the assistant editors, who have been patient with our tardiness in submitting copy on some occasions, and to the many individuals who have contributed to this page, we express our sincere appreciation. In the latter regard, the members of the staff of Kentucky Physicians Mutual have been especially helpful.

Most of all, we are grateful to those readers of The Journal who have taken the time to peruse our editorial efforts. We have enjoyed these five years—we hope that you have!

W. VINSON PIERCE, M.D.



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carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg.

rational combination therapy for sprains and strains: relaxes muscle, relieves pain. Also available with ¼ gr. codeine as 'SOMA' COMPOUND with CODEINE: carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg., codeine phosphate 16 mg. (Warning: may be habit-forming.)

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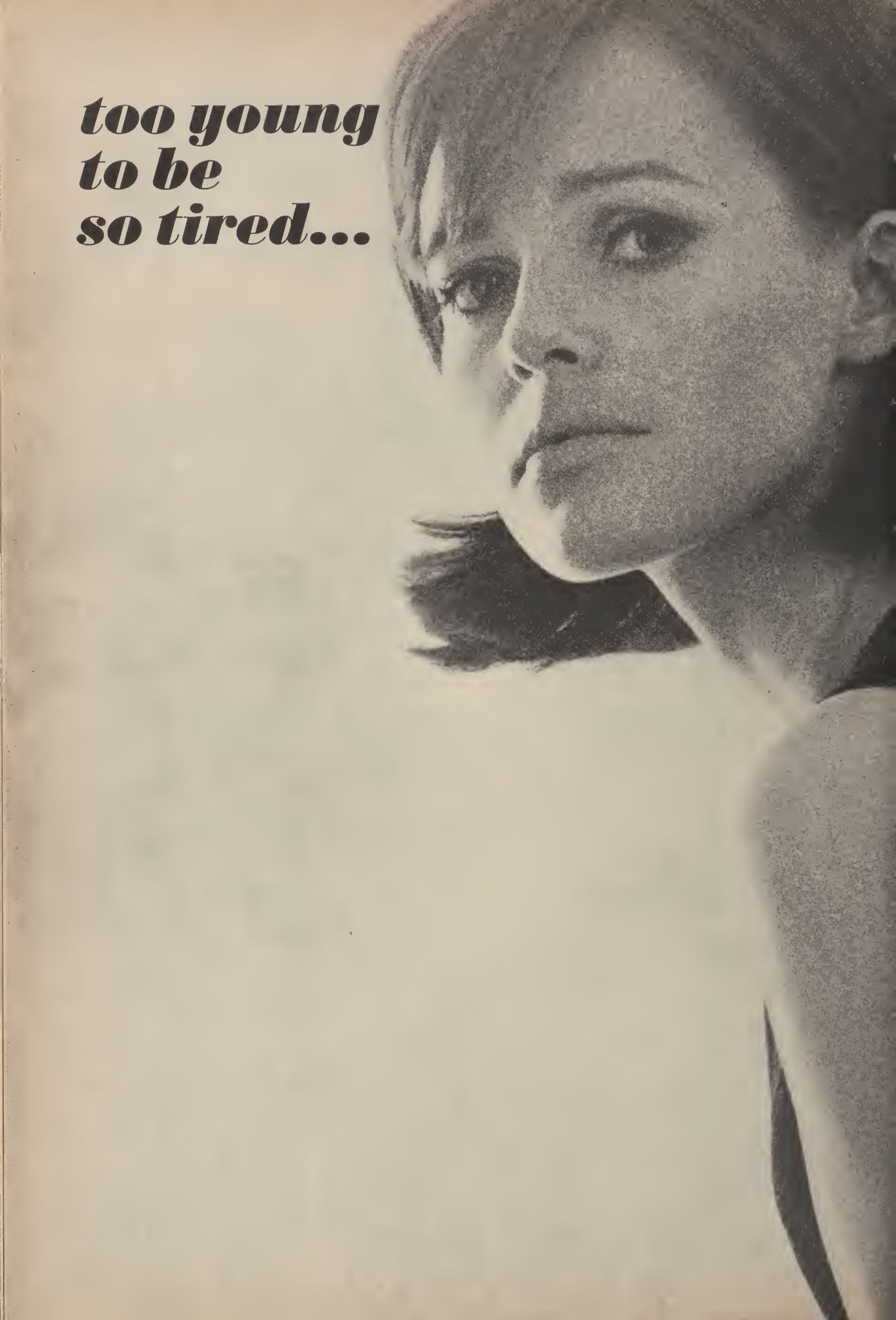

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AS THE old year draws to a close, we on the staff of The Journal would like to express our appreciation for the support which *you,* our advertisers, have given us during 1964.

WE ARE grateful for your valuable contribution to The Journal of KMA during the past twelve months—and with your help, look forward to making our Journal more attractive, useful and readable in the coming year.

TO EACH of you, our advertisers, we would like to extend our very best wishes for a happy holiday season and prosperity in the New Year.

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IN THE BOOKS

CURRENT THERAPY, 1964; edited by H. F. Conn, M.D.; Published by W. B. Saunders Co., Philadelphia, 1964; 797 pages, price, $13.00.

This is the 16th edition of a well-known annual volume which is of great value to medical practitioners. As in the past, the topics covered are extensive but not exhaustive. Each chapter is prepared by an individual of recognized competence. It is a virtue of this series that the topics and points of view of the authors vary from volume to volume so that a well-rounded coverage of controversial areas is obtained over a period of time. A case in point is the therapy of hyperthyroidism, this year the surgical point of view is stressed. A medical program for treating peptic ulcers is well presented.

A table of normal laboratory values is printed on the inside face of both covers. The extensive section on pediatric dosages is very useful. A valuable section on poisons describes not only the treatment of specific poisons but also lists the Poison Control Centers in the United States and the types of poisonous substances present in various common household items.

The print and paper are excellent and well able to withstand the use this volume deserves and will get.

E. Douglas Rees, M.D.

EMERGENCY TREATMENT AND MANAGEMENT, Third Edition: by Thomas Flint, Jr., M.D.; Published by W. B. Saunders Co., Philadelphia, 1964; 686 pages, price, $8.75.

The third edition of Dr. Flint's book is a most current, complete, and comprehensive treatise of the subject. "Emergency Treatment and Management," presented in outline form pleasantly devoid of verbiage.

The subject matter is well grouped together for rapid and easy identification.

The author devotes 182 pages to the care of poisoning, presenting the subject in a precise step-by-step manner of treatment with an excellent cross reference, when needed.

The procedure to follow when confronted with emergency situations is brief and factual. The author also states in an equally lucid manner what not to do. This is equally important.

The medical-legal aspects of emergency treatment are very clearly portrayed.

The fact that the index and cross reference system is so complete adds to the value of this edition for a quick reference in emergency care.

Should one need a manual to help him remember what to do in the care of an emergency, this book will furnish the desired information quickly and accurately.

Hobart D. Belknap, M.D.

TEXTBOOK OF PEDIATRICS, Eighth Edition: edited by Waldo E. Nelson, M.D.; Published by W. B. Saunders Co., Philadelphia, 1964; 1636 pages, price, $18.00.

Twenty years ago Dr. Waldo Nelson "reluctantly" took over the editorship of this internationally famous major text on pediatrics. That was the fourth edition and now we have the eighth.

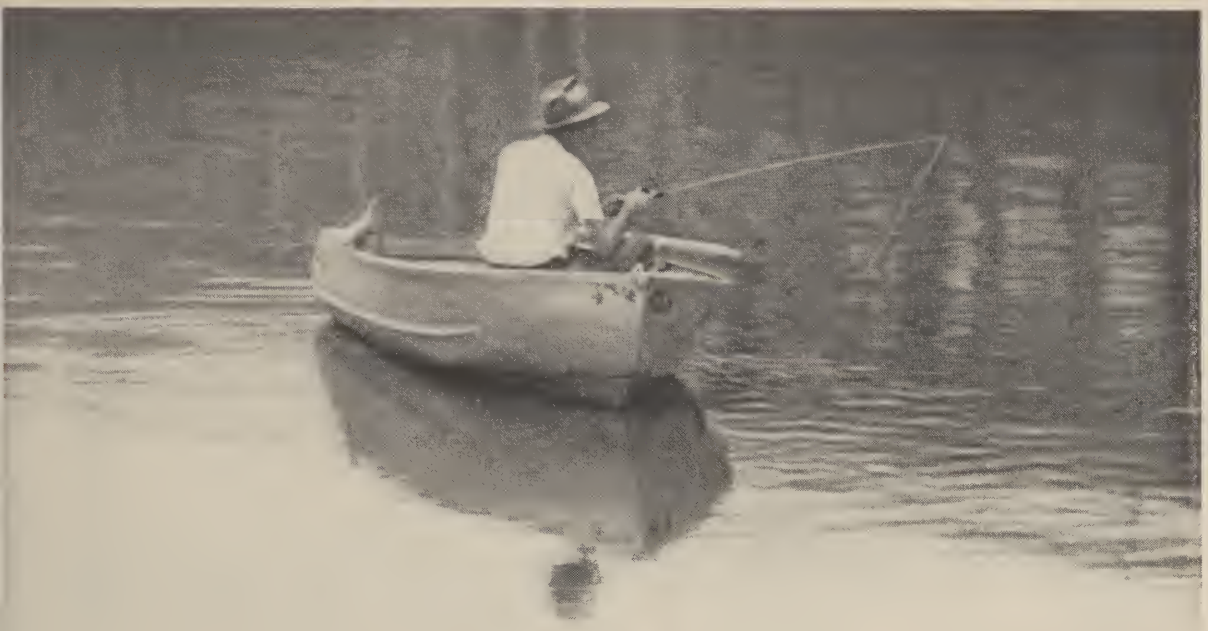
It must be rare for such a book and its sequential editions to have always sequentially improved also, and not to have grown and grown in size out of all proportions. Now the eighty-five contributors, who read as a Who's Who in Pediatrics, have again been guided and brought together to produce this, the finest edition so far.

The eighth edition has been revised and brought up-to-date and published in a short time—an important consideration in a constantly developing and changing specialty. Particularly is this so in the field of peri-natal factors and disease.

The Saunders Company are rightly proud of this major text; what a long and happy marriage they have had with Dr. Waldo Nelson. The book is, of course, a must for any centre or individual concerned with pediatrics.

I have one complaint: Dr. Nelson's daughters have always helped (from the time they could read) with the publication of the editions. In the seventh, being responsible for and exhausted in the preparation of the Index, they managed to insert in it, entirely missed by publisher and editor, the delightful item: "Birds. for the. pages 1-1413". The book was 1413 pages long. This filial barb has been eliminated. The Nelson warmth and scholarship is, however, still there.

Frank Falkner, M.D.



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Surgical Management of Inflammatory Lesions of the Pancreas†*

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Lexington, Ky.

Acute pancreatitis is often related to alcoholism and gallstones. Although this condition is best treated conservatively, its diagnosis may require laparotomy to exclude other potentially surgical conditions. The complications of acute pancreatitis are best treated surgically.

THE conditions included in this discussion are acute pancreatitis and its sequellae: pancreatic pseudocyst, pancreatic abscess and chronic pancreatitis.

Etiology

The etiology of acute pancreatitis remains to be clarified. Since Opie's original description[1] of a gall stone impacted in the ampulla of Vater causing reflux of bile into the pancreatic duct, bile reflux has often been invoked to explain the etiology of acute pancreatitis. However, this occurrence is a pathological rarity and its importance as an etiological factor is doubtful because of studies showing that bile reflux is of little consequence.[2] Probably the most important factor in the genesis of acute pancreatitis is pancreatic ductal obstruction[3] from a stone, from spasm of the sphincter of Oddi or in rare instances by an adenocarcinoma of the head of the pancreas. Other possible etiological mechanisms are changes in pancreatic blood flow and a local auto-immune reaction. Pancreatic trauma resulting either from a blow to the epigastrium or from pancreatic injury during gastric surgery is an occasional cause of acute pancreatitis. Whatever the intimate mechanism may be, the essential change taking place during an attack of acute pancreatitis is an egress of pancreatic juice containing active proteolytic enzymes into the interstitial tissues of the pancreas and thence into the peripancreatic tissues causing in its passage severe inflammation and hemorrhage.

Although there is no good explanation for this relationship, it is well known that chronic alcoholism or chronic cholecystitis is associated with approximately 90% of cases of acute pancreatitis. In some centers the incidence of associated alcoholism approaches 100%.

Clinical Manifestations

The salient clinical manifestation of acute pancreatitis is epigastric pain. Characteristically, the pain radiates to the back and may be relieved by placing the patient in the sitting position. Patients often discover this by themselves and adopt a kneeling position in bed. Frequently the pain is so rapid in onset that it may be characterized as apoplectic. Although extremely severe attacks are accompanied by some

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Figure 1. Anterior displacement of stomach by swollen pancreas and edematous peri-pancreatic tissues.

signs of peritoneal irritation, in the vast majority of cases one does not find the board-like abdominal rigidity typical of acute peritonitis due to perforation of a hollow viscus. Epigastric and left upper quadrant tenderness are usually present. Bowel sounds are hypoactive or absent. There is always some degree of paralytic ileus.

In very severe cases, evidence of retroperitoneal hemorrhage may be found in the form of a bluish discoloration or bruising in the left flank within 12 to 24 hours after the onset of the attack. This is known as Gray-Turner's sign. About 25% of the patients have clinical jaundice.

In the early phase of the illness the temperature is, as a rule, only moderately elevated. The pulse is frequently rapid and the rapid pulse along with a falling blood pressure is a harbinger of the redoubtable shock which to varying degrees is present in the majority of cases.

Radiology

There are no direct radiological signs of acute pancreatitis. There are, however, several indirect radiological findings which point to this diagnosis. A flat plate of the abdomen may reveal a dilated loop of proximal small bowel representing paralytic ileus localized to a loop of small intestine adjacent to the inflamed pancreas (sentinel ileus). An upper G.I. series taken within the first 24 to 48 hours after the onset of acute pancreatitis may show anterior displacement of the stomach by the edematous pancreas and peripancreatic tissues (Figure 1). A very valuable diagnostic clue to the existence of acute pancreatitis is the finding of either a left sided pleural effusion, or an area of discoid atelectasis in one of the lower lobes. This pathology usually appears within 24 to 48 hours following the onset of the attack. These findings in a patient with an acute abdominal condition strongly suggest acute pancreatitis.

Laboratory Findings

(a) *Serum Amylase:* Serum amylase is elevated in approximately 60-70% of cases. This remains the most useful diagnostic test and should be performed routinely in all patients with an acute abdomen, particularly with a history of alcoholism. In general the serum amylase remains elevated for 24 to 72 hours and then gradually returns to normal. Sustained high levels indicate continuing severe disease. With extremely severe pancreatitis accompanied by widespread pancreatic necrosis, enzyme levels may be only moderately elevated. It is important to remember that there are several causes other than acute pancreatitis for a high serum amylase:

—perforated duodenal ulcer.

—small bowel obstruction with strangulated intestine.

—mesenteric vascular occlusion.

—acute cholecystitis.

—mumps.

Since the management of acute pancreatitis is generally conservative, it is obvious that non-intervention on the basis of the serum amylase alone would have catastrophic results in these other conditions except for mumps, of course.

In a healthy individual the administration of analgesic agents such as morphine and codeine may increase the serum amylase. The clinician should be aware of this before evaluating the laboratory data.

When pleural effusion is associated with acute pancreatitis, the pleural fluid contains very high amylase levels. Fluid withdrawn from the peritoneal cavity of a patient with acute pancreatitis by a peritoneal tap contains a high amylase level. This can also lead to diagnostic errors since the same will be true for peritoneal fluid in all the conditions listed above except cholecystitis. The only point that may be of some help is that a smear of peritoneal fluid in cases of strangulated intestine usually shows massive bacterial contamination not seen early

in the course of acute pancreatitis or perforated duodenal ulcer.

(b) *Serum Lipase*: Serum lipase values may be of help to the clinician since they remain elevated for longer periods of time after the acute attack. However, the test is not as easily accomplished as determination of serum amylase and therefore is not carried out frequently.

(c) *Blood Sugar:* Hyperglycemia is present in approximately 10% of cases of acute pancreatitis particularly of the severe variety and is due to damage of the islets of Langerhans by the diffuse pancreatic inflammatory process.

(d) *Serum Bilirubin:* Jaundice is found in approximately 25% of cases of acute pancreatitis and results from obstruction of the common bile duct by the same stone responsible for the acute pancreatitis or from an actual hepatitis caused by the high blood levels of pancreatic proteases or from involvement of the distal segment of the common bile duct in the pancreatic inflammation.

(e) *Serum Calcium:* Frequently the serum calcium falls, sometimes to levels low enough to cause tetany. Combination of ionized calcium with fatty acids liberated or hydrolysis of neutral fat causes the hypocalcemia. The degree of lowering of serum calcium is an index of the amount of fat necrosis taking place and in turn of the severity of the disease. A serum calcium low enough to cause tetany is usually a sign of grave prognostic significance.

(f) *Serum Magnesium:* Only recently has it been recognized that a fall in serum magnesium may also occur during an attack of acute pancreatitis.[4] In our experience, this is more frequent in alcoholics.

(g) *Serum Triglycerides:* Occasionally the clinician may encounter frankly hyperlipemic serum upon withdrawing blood from a patient with acute pancreatitis. The relationship of hyperlipemia to pancreatitis is an interesting one. Familial hyperlipemia, a relatively rare condition, is frequently accompanied by acute pancreatitis particularly of the chronic relapsing variety.[5] On the other hand, acute pancreatitis, for unknown reasons, is sometimes associated with transitory hyperlipemia that recedes as the attack subsides. It is interesting that hyperlipemia occasionally accompanies experimental pancreatitis in dogs.

Management

The therapeutic goals in the management of acute pancreatitis are as follows:

1. *Treatment of Shock:* The corner stone of the management of acute pancreatitis lies in the prompt recognition and treatment of shock which to varying degrees is almost always present. Hypovolemic shock is the usual cause of death during the early course of the illness. The degree of shock may not be recognized because of the intense hemoconcentration resulting in high hematocrit and hemoglobin levels despite large blood and plasma volume deficits. Often the hypotension is out of proportion to the fall in blood volume and this has led to the recognition that toxic vaso-action substances such as bradykinin probably play a contributory role. Regardless of the nature of the responsible factors, treatment remains the same: vigorous blood transfusion in amounts necessary to restore the blood pressure to normal levels. When the hemoconcentration is severe, we administer serum albumin as a 25% solution in amounts of 200 to 300 ml. daily. Non colloid intravenous fluids should be given concomitantly to maintain nomal urinary output. Needless to say, in a seriously ill patient the latter can be monitored only by means of an indwelling urinary catheter. Related to the shock or to other unrecognized factors, acute renal failure is another frequent cause of early death in acute pancreatitis. When the serum calcium is low, calcium should be administered as a 10% solution of calcium gluconate in amounts of 10 to 20 ml. per day intravenously. Vasopressors should be used only as a last resort.

2. *Relief of pain:* As previously mentioned the pain experienced by patients with acute pancreatitis may be excruciating and demands prompt relief. Unfortunately, all analgesic agents, including meperidine, have a spasmogenic effect on the sphincter of Oddi and are theoretically capable of aggravating the underlying pathology. Therefore their use, particularly in large amounts, is contraindicated. When the pain experienced by the patient is severe enough to necessitate large amounts of narcotics for its relief, a splanchnic block should be performed immediately. When the pain is only of a mild degree small doses of meperidine accompanied by atropine (or a similar anticholinergic) can be used safely.

3. *Temporary inhibition of pancreatic secretion:* Practically all of the manifestations of

pancreatitis result from digestion of the gland and surrounding tissues and often of tissues at distant sites by pancreatic enzymes particularly those with proteolytic activity. Therefore, one of the therapeutic goals is to place the pancreas at rest. This is achieved both by naso-gastric suction and by anticholinergic agents. Naso-gastric suction, by preventing gastric acid secretions from reaching the duodenum diminishes the amount of secretin elaborated by the mucosa of the duodenum and in turn prevents pancreatic stimulation via that route. Anticholinergic agents tend to depress pancreatic secretion of enzymes.

4. *Prevention of infection:* As will be discussed below, infection supervening in the necrotic peripancreatic tissues is one of the most redoubtable conditions the surgeon can be called upon to treat. In so far as possible one should take whatever measures are available to prevent this. In our opinion acute pancreatitis is one of the few conditions in which the preventive administration of antibiotics should be a matter of routine. How effective this approach is in preventing pancreatic abscess and peripancreatic abscess is of course only a matter of conjecture.

The conservative treatment of acute pancreatitis, as outlined in the preceding paragraph, has been responsible over the past 10 years for a gradual decrease in the early mortality from approximately 25% to approximately 5 to 10%. Undoubtedly, a conservative approach is far better than systematic surgical intervention. However, differentiation between acute pancreatitis and some other acute abdominal condition for which surgical exploration is mandatory is often not possible. Whenever there is the slightest doubt the clinician should always lean in the direction of exploratory laparotomy because the consequences of nonintervention in a case of perforated duodenal ulcer or strangulated small bowel are disastrous whereas a simple coeliotomy in face of acute pancreatitis is usually of little consequence as long as the surgeon refrains from injudicious intraperitoneal manipulations. When biliary tract disease is found it should be treated by the most expeditious approach, i.e., cholecystostomy in preference to cholecystectomy. Such procedures as sphincterotomy have, in our opinion, absolutely no place in the management of acute pancreatitis. The peritoneal cavity should be thoroughly lavaged with liberal amounts of normal saline solution prior to closure. The pancreas should not be drained for fear of infecting the area or creating an external pancreatic fistula.

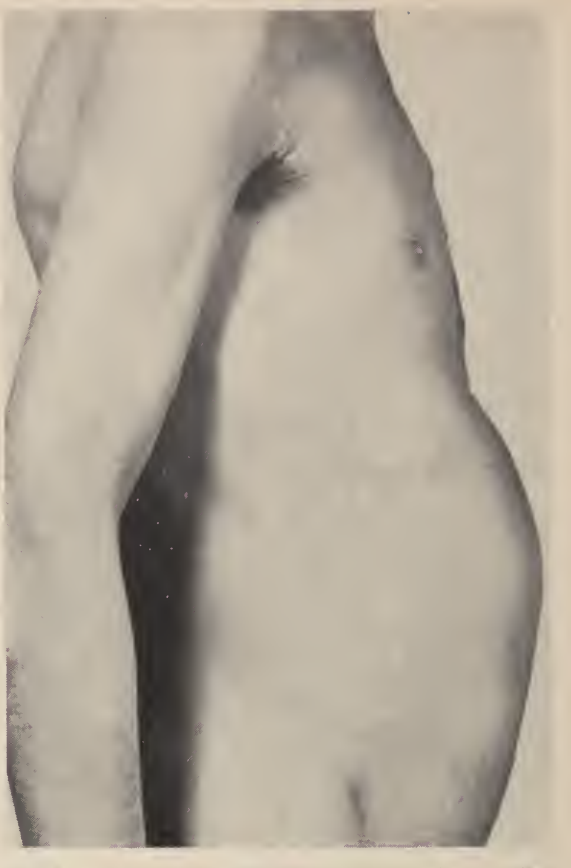


Figure 2. Characteristic abdominal deformity in a patient with a large pancreatic pseudocyst.

Prior to the advent of the modern conservative management of acute pancreatitis the majority of deaths occurred during the first week of the illness. At the present time the majority of deaths that do occur are delayed and are caused by complications of acute pancreatitis some of which are discussed below.

Pancreatic Pseudocyst

Almost always, pancreatic pseudocyst complicates acute pancreatitis either of spontaneous or traumatic origin; occasionally it occurs as a complication of pancreatic ductal obstruction by an adenocarcinoma of the head of the pancreas. A pseudocyst is formed by exudate which, during the initial phases of the attack of pancreatitis, seeps out of the gland along retroperitoneal tissue planes. When this extravasation of fluid is massive, loculation takes place in one of several areas: above the stomach, behind the gastrohepatic ligament, be-

tween the leaves of the transverse mesocolon or within the leaves of the mesentery of the small bowel. However, by far the most frequent site of fluid accumulation is the lesser peritoneal cavity where the fluid becomes sequestered by the posterior wall of the stomach, the gastrocolic ligament and the transverse mesocolon. Thus a fluid filled pocket lined by granulation tissue is formed. Not being a tumor, a pancreatic pseudocyst cannot be excised. Occasionally the overly temeritous surgeon may attempt to do so to his eventual chagrin.

The recognition of a pancreatic pseudocyst is usually simple and is based upon the finding of an epigastric mass (Figure 2) developing rapidly in a patient having recently had an attack of acute pancreatitis. The mass is almost always palpable, is sometimes fluctuant and, an important characteristic, does not move with respiration. Another diagnostic feature of pseudocysts is their amazing tendency to wide and rapid changes in size. We have seen secondary shock appear in patients because of rapid accumulation of fluid in the cyst.

Radiology may help in the diagnosis of small cysts by showing displacement of the surrounding viscera. A pseudocyst in its usual location displaces the stomach anteriorly and the transverse colon inferiorly. Occasionally, a false positive diagnosis of pseudocyst results from attributing displacement of the stomach by an enlarged left lobe of the liver to a pseudocyst. This problem may occur in alcoholics who of course, are liable both to pancreatitis and cirrhosis of the liver.

Potentially, a patient harbouring a pseudocyst is exposed to the serious complication of an internal fistula developing into the G.I. tract. The proteolytic enzymes in the pseudocyst frequently erode the cyst wall. Perforation can take place into the free peritoneal cavity with resulting peritonitis or more frequently as a fistula between the cyst and one of the surrounding viscera: stomach, duodenum or transverse colon (Figure 3). Severe, sometimes fulminating hemorrhage usually accompanies erosion of the bowel wall. The occurrence of G.I. hemorrhage, upper or lower, in a patient known to have a pancreatic pseudocyst signifies erosion of the cyst into the gastrointestinal tract.

The reason pancreatic pseudocysts do not regress spontaneously is a frequently raised question. Although this happens occasionally,

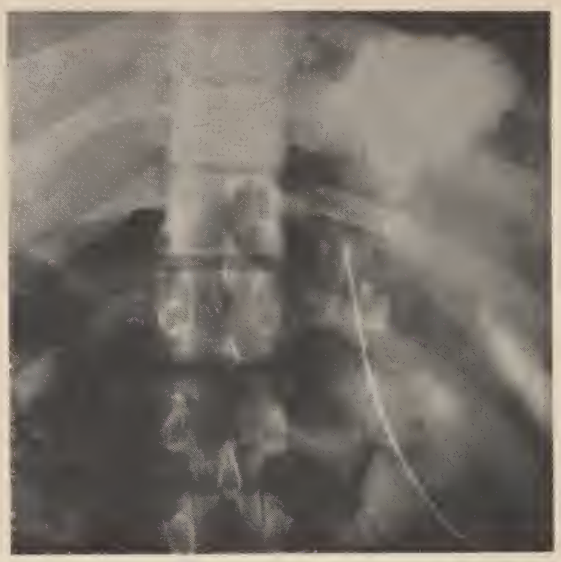


Figure 3. Pancreatic pseudocyst treated by external drainage. A fistula has formed between the cyst cavity and the stomach. Dye injected into the cyst enters the stomach.

in the majority of instances these lesions expand. This chronicity is due to the existence of a communication between the cyst and the pancreatic ductal system via which pancreatic juice continues to enter the cyst. The amount of juice entering the cyst and conversely any spontaneous decompression of the cyst via this communication depends upon the degree of pancreatic ductal obstruction. The latter may vary and this explains why the size of pancreatic pseudocysts often fluctuates tremendously. This connection between the cyst and the pancreatic ducts is responsible for the immediate pancreatic fistula usually complicating an ill-advised external drainage of a pseudocyst. In addition, a pancreatic pseudocyst, similarly to a hematoma tends to expand because as the blood in the cyst is digested by proteolytic enzymes the osmolarity of the cyst fluid increases leading to a shift of extracellular fluid into the cyst.

Management: Management of a recognized pseudocyst is always surgical. For reasons just mentioned, older techniques such as marsupialization or external drainage should be abandoned in preference for some types of internal drainage. Because of the communication between the pancreatic ducts and the cyst, it would seem theoretically feasible to decompress a cyst via the pancreatic duct by means of a sphincterotomy. Unfortunately the size of the communication between the cyst and the pancreatic ductal system is so small and variable that decompression of the cyst via the pancreatic ducts is not practical except under cer-

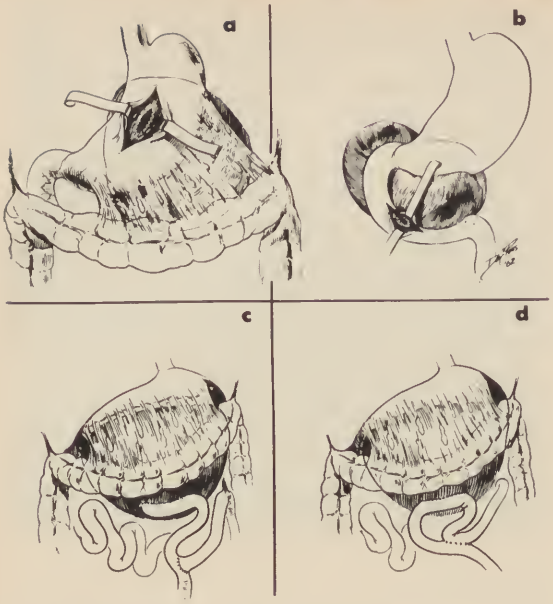


Figure 4. Various methods by which internal drainage of pancreatic pseudocyst may be performed.

tain selected conditions. The preferred method of treatmcnt is to drain the cyst into the gastrointestinal tract by making an anastomosis either between the cyst and the stomach, the cyst and the duodenum, or between the cyst and a loop of jejunum (Figure 4). We prefer the latter technique. This approach to the management of pancreatic pseudocyst offers virtual certainty of cure with minimal mortality and morbidity.

Peripancreatic Abscess

Occasionally the necrotic peripancreatic tissue bccomes infected and a peripancreatic abscess develops. This is a particularly grave complication because the abscess instcad of becoming walled off as abscesses of other origins usually do, tends to spread along retroperitoneal planes opened up by the pancreatic exudate. Thus, thesc abscesses often dissect widcly around the pancreas. The signs of a peripancreatic abscess are spiking fever and a high white count occurring within one or two weeks after an attack of acute pancreatitis. The gravity of this complication may be compounded by severe hemorrhage due to digestion by pancreatic trypsin of large vessels involved in the abscess.[6] When the patient has had a previous surgical exploration, this complication is announced by profuse bleeding along drain sites.

Small, well localized abscesses usually respond to simple drainage. The diffuse lesions extending widely in the retroperitoneal space around the pancreas are extrcmely difficult to treat since this space does not lend itself well to external drainage. Anterior drainage by means of sump drains or Penrose drains is inefficient because of the posterior location of the collcction and because the latter usually contains clumps of partially digested fat and blood clot. We have found that the only successful way to drain peripancreatic abscesses is via a large left flank incision opening directly into thc retroperitoneal space. The incision is left partially open to permit daily lavage of the abscess cavity.

Chronic Pancreatitis

Traditionally, all cases of acute pancreatitis have been lumped together. In such series one finds that the majority of the patients either have gall stones or arc chronic alcoholics. More and more it is realized that pancreatitis associated with gall stones must be completely separated from the pancreatic changes seen in chronic alcoholics.

The diagnosis of chronic relapsing pancreatitis is based upon the repeated occurrence of attacks of epigastric pain which may vary in degree all the way from minor attacks of "indigestion" to extremely severe pain requiring hospital admission. Serum amylase levcls measured during such an attack, are usually elevated. In other words each attack of this chronic condition simulates a small attack of acute pancreatitis. Characteristically, after many such attacks, each subsequent episode decreases in scverity as the pancreas becomes replaced by inflammatory scar tissue. Thc acute episodes of pain are replaced by almost continuous dull

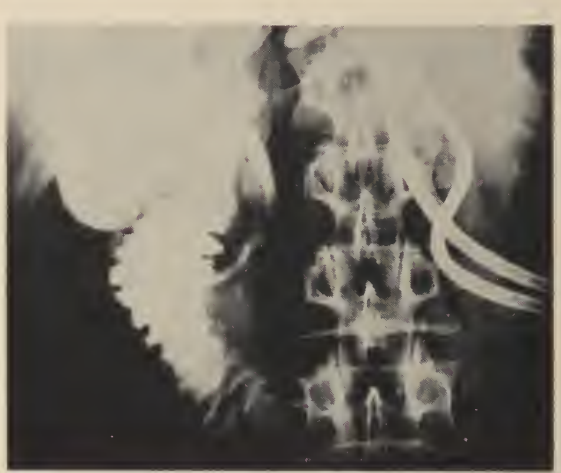


Figure 5. Long cicatricial stricture of the common bile duct in a patient with chronic pancreatitis.

Figure 6. Characteristic pancreatic calcification in a patient with chronic pancreatitis. With rare exceptions, this picture is associated with chronic alcoholism.

epigastric pain. The destroyed pancreas gradually loses its exocrine function and a syndrome of malabsorbtion and weight loss supervenes. In the final stages of the illness, involvement of the islets of Langerhans by the chronic inflammatory process is responsible for diabetes. Frequently the chronic cicatricial process in the pancreas involves the common bile duct as it runs through the head of the gland and causes a stricture of the duct and obstructive jaundice. (Figure 5)

Typical cases of far advanced pancreatitis are easily recognizable particularly if pancreatic calcification is present (Figure 6). Early in the course of the illness, diagnosis may be more difficult especially if one is not able to measure the serum amylase during an acute attack. The only way to make the diagnosis under these conditions is to carry out a secretin test and demonstrate a decreased rate of secretion of pancreatic juice along with a decreased concentration of bicarbonate ion in the juice. If the patient has associated chronic cholelithiasis or chronic alcoholism, the suspicion of chronic pancreatitis is always much higher. When chronic pancreatitis has disease of the biliary tract as its etiology, the course is far more benign. Attacks are not as frequent and as severe and, of great importance to the clinician, the condition is far more amenable to treatment. Much of the controversy that has centered around the treatment of chronic pancreatitis is due to the above mentioned fact that the varying nature of the disease according to its etiology has not been recognized. For instance, the results of sphincterotomy performed on series of cases of chronic pancreatitis have not been evaluated with respect to the biliary or alcoholic origin of the pancreatitis. It has become quite apparent to us that when chronic pancreatitis is associated with biliary tract disease—usually chronic cholelithiasis—cholecystectomy and if necessary choledochotomy is sufficient to provide a lasting cure. In such cases we no longer carry out sphincterotomy unless the operative cholangiogram shows very clear evidence of a stricture at the level of the sphinter of Oddi.

The problem of management is entirely different when dealing with chronic relapsing pancreatitis in alcoholics. In these cases the disease is far more severe and its course far more relentless. The picture of calcified pancreas with severe exocrine deficiency resulting in a pronounced weight loss and diabetes is almost always associated with chronic alcoholism. Usually one is unable to find biliary tract disease in these patients except for acquired benign stricture of the distal segment of the bile duct resulting from the pancreatitis as described earlier. As one would expect, empirical cholecystectomy and sphincterotomy in the absence of any disease of the biliary tract has been most disappointing. Many other procedures have been utilized to treat this most difficult condition: vagotomy, subtotal gastric resection, sympathectomy, coeliac ganglionectomy, distal pancreatectomy, pancreato-duodenectomy. During the last decade, however, the most popular procedure has been retrograde decompression of the pancreatic duct. The rationale for this procedure lies in the multiple areas of stenosis of the pancreatic duct with dilatation of the duct in the tail of the gland which can be demonstrated by operative pancreatogram. Since these areas of stricture formation are proximal to the sphincter, a sphincterotomy could not be expected to relieve the obstructive process. Decompression of the pancreatic ductal system at the tail of the gland by means of a Roux-en-Y loop is a more logical procedure.[8] The success obtained with this operation performed in various centers around the country has been fair. In our experience patients have experienced immediate symptomatic relief of pain. Unfortunately, the long term results have been

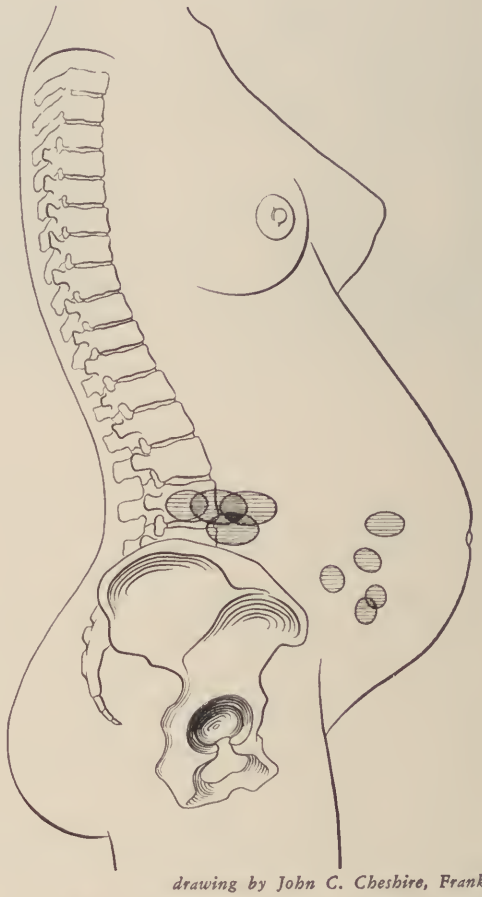
Continued on Page 1035

Appendicitis in Pregnancy

THOMAS H. BAKER, M.D.
Frankfort, Ky.

Appendicitis after the first trimester may be quite difficult to diagnose, as the classical signs are often absent. The pain and tenderness may mimic pyelitis of pregnancy perfectly.

ABOUT once every thousand deliveries an appendectomy is performed on a pregnant woman. Approximately half of these cases prove to have an acutely inflamed appendix.[5, 6, 7, 9] In private practice the opportunity to observe a number of true appendicitis cases during gestation is necessarily limited by the volume required to accumulate experience in the diagnosis. Since 80% of the cases reported in large series are seen during the first six months of gestation[9] little has been recorded about the more advanced pregnancy. During the first twelve weeks appendicitis is quite like that seen in the non-pregnant woman and will not be discussed except to say that it is most commonly confused with acute salpingitis and ectopic pregnancy.[6] Recently a tenth case of acute appendicitis in pregnancy has been made available to me for examination and comparison with the others seen during the past four years. The stage of gestation ranges from 14 to 34 weeks, most falling between 19 to 32 weeks. A few facts are worth presenting from this small series.



drawing by John C. Cheshire, Frankfort

Figure 1. Areas of Maximum Tenderness in Ten Cases of Acute Appendicitis During Pregnancy.

Diagnosis

Physical examination was deceptively innocent in some cases despite rather advanced degrees of inflammation. No patient showed a temperature elevation on admission to the hospital greater than 99.8 degrees except for one young girl with an appendix ruptured after 72 hours of abdominal pain. She had been treated by her doctor for gastroenteritis with paregoric and had failed to return for re-examination the following morning. In all these cases the abdomen was perfectly soft with no suggestion of muscle spasm. The ruptured appendix case mentioned above had full-blown peritonitis and her abdomen could be palpated with no muscular resistance. Another striking finding was the absolute lack of rebound pain on release of the abdominal wall in over half of the patients. The surgeon must orient his thinking to these facts after having been conditioned to rely on them. The white blood count was frequently of no value. Several severe cases had a normal white count, while others which were mild had elevated counts. The physiologic elevation of the white blood count during pregnancy is confusing as well.

Pain and tenderness were always present somewhere on the right side.[7] This tended to be higher as the pregnancy advanced, but not always. One late case with a low-lying long appendix experienced pain in the right inguinal

area, while one early case with a retrocaecal appendix complained of pain in the kidney area. In general, however, tenderness was much more diffuse and posterior than is usually stated, tending to be located higher and posterio-lateral as the pregnancy progressed. (see illustration)

It is commonly taught that abruptio, torsion of an adnexal mass, uterine infection, and ureteral stone are the conditions which are usually simulated by appendicitis in pregnancy.[6] On the contrary, most of these cases were thought to be pyelonephritis when first seen, and this was the disease most difficult to rule out.[3, 14] It is not too unusual to have an acutely infected, poorly draining kidney which does not lend itself to early diagnosis on urinalysis. Many cases were seen just at the time that the uterus is thought to exert its greatest effect in blocking ureteral peristalsis. The diffuse right flank pain is quite deceptive and may mimic kidney infection perfectly. A strong point against this condition was the lack of spiking fever and chills associated with a greatly elevated white count which should have been present if an acutely inflamed and blocked kidney were the cause of the pain. In one case the deception was so exact that an intravenous pyelogram (shielding the pregnancy and taking one film) was taken, demonstrating excellent drainage and prompting laparotomy.

During the last half of pregnancy pelvic and rectal examinations were normal. A far advanced case of peritonitis had no tenderness on deep rectal palpation. A very significant and always present finding was a definite increase in pain when lying on the right side, relieved when lying on the left side. This is in contrast to "round ligament pain" which is the reverse. Most patients complained bitterly when asked to turn on the right side. A history of high epigastric pain with secondary nausea which "changed" and shifted to somewhere in the right half of the abdomen, flank or back was especially reliable and could almost always be obtained with careful questioning. After about twelve hours the pain may be quite diffuse and at times is experienced as a dull ache throughout the entire right flank extending down the right anterior and medial thigh. The poor localization of pain coupled with few signs of peritoneal irritation make the early symptoms especially important in accurate diagnosis. In many cases physical examination was almost worthless and the history was the only reliable evidence that an inflamed appendix was hidden beneath the gravid uterus.

Treatment

It is natural to be hesitant in operating on the pregnant woman when the usual localizing signs are not present. Conditioned to finding certain physical signs and usually slightly insecure in his dealings with the gravid uterus, the surgeon may be reluctant to open the peritoneal cavity for fear of interrupting pregnancy after

Table I.

Patients With Acute Appendicitis During Pregnancy

Case	Age	Weeks	WBC	Temp. (Adm.)	Spasm	Rebound	Tenderness	Incision	Result
No. 1	23	14	15,000	99.0	0	3+	McBurney's pt.	McBurney	5# infant, surv.
No. 2	17	19	25,400	99.6	0	3+	McBurney's pt.	McBurney	term delivery
No. 3	16	22	10,000	98.6	0	0	1" superio-medial ant. sup. il. spine	R. paramedian	pre-eclampsia near term
No. 4	24	26	7,800	99.0	0	3+	level of umbilicus R. flank & CVA	R. paramedian	6# infant, surv.
No. 5	23	30	11,350	99.8	0	0	above crest, R. flank	long McBur.	term delivery
No. 6	18	32	13,600	98.2	0	3+	level umbilicus, 6cms to right	R. paramedian	term delivery
No. 7	32	32	12,850	99.6	0	0	level of crest, R. flank & CVA	R. paramedian	unknown; moved
No. 8	24	29	13,000	99.2	0	0	level of crest, R. flank & CVA	high TV split	unknown
No. 9	30	24	8,500	99.8	0	2+	R. flank & CVA, level of umbilicus	R. paramedian	placenta prev. infant died
No. 10	19	34	14,500	103.0	0	0	2" above McBurney's area	oblique	delivered 24 hrs infant surv.

removal of a normal appendix. A careful appendectomy in itself has little effect on pregnancy.[7] Acute appendicitis, on the other hand, causes significant fetal and maternal loss if not treated promptly.[8] Hesitancy and reluctance must be overcome. Localizing signs may never occur. Peritonitis is extremely serious in the gravid patient since the usual protective mechanisms are hampered by the physical presence of the pregnancy. If the inflammatory process is advanced, especially if the uterine wall itself is irritated from intimate contact with the appendix, all the progesterone in the hospital pharmacy will not prevent premature labor.[3, 7, 11] It seems that some form of progesterone is always given to these patients, but very doubtful if any beneficial effect is produced in the uterus. The doctor usually feels better after prescribing it, if not the patient.

If the fetus is viable, sedation should be with narcotics in minimal amounts. Should labor ensue, there is little danger of wound disruption,[3] but to play safe, forceps should be applied as soon as practical to avoid pushing efforts. Regional anesthesia is preferred for the same reason, and narcotic antagonists to give the premature infant every chance. Uterine manipulation should of course be avoided. If cesarean section is necessary on obstetrical grounds, in the face of peritonitis, hysterectomy may be lifesaving.

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The Role and Contributions of the Psychiatrist in Private Practice†

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Since World War II the practice of psychiatry has moved from the large state mental hospital to the community with the psychiatrist in private practice as are the majority of physicians. A historical review of the mental health movement is presented.

MEDICINE and its institutions have traditionally accepted responsibility for the diagnosis and treatment of disease. At the same time, community participation has come through the public health movement and its institutions for the control of communicable disease. If the diagnosis and treatment of emotional and mental illness are the responsibility of the medical profession and its institutions, the preservation and enhancement of the mental well-being of its members is the obligation of society and the community. There is no clear-cut borderline between these functions, but it is becoming increasingly evident that the promotion and support of mental health are a community responsibility.

Traditionally, psychiatry has concerned itself with the diagnosis and treatment of mental disorders. It is only since the second decade of this century that psychiatry has begun to concern itself with community mental health, this largely through mental health or hygiene organizations.

History

The earliest mental health movement concerned itself first of all with housing for the mentally ill and secondly with humane care. The significance of Phillipe Pinel of Paris and the Tuke family of York, England, can never be over-estimated in both these regards. The prestige of Pinel caused psychiatrists to give serious attention to his methods, while the approach to the care of the mentally ill employed by Samuel and D. Hack Tuke at the Retreat in York, England, had much impact on the Quakers and their spread of these attitudes to America. Another early influence in the care of the mentally ill stems from the significance to the colonial medical profession of Benjamin Rush, who from 1783 devoted a considerable part of his time and interest to the problems of mental illness. His association with the Pennsylvania Hospital had much to do with the fact that in 1841 it was the first general hospital in this country to erect a wing for the care of the mentally ill.

As for social attitudes regarding mental illness, the first half of the 19th century in this country was characterized by the association of mental illness with pauperism, resulting in a hapless deterioration in the concept of care for mental illness, as well as in attitudes toward those suffering from it. Poor houses became, in great part, also mental hospitals, with consequent abuses of the persons and property of the mentally ill. These conditions set the stage for Dorothea Lynde Dix who conducted a crusade unparralled in history on behalf of the mentally ill. As a direct result of her efforts, mental illness had begun to free itself from the problems of pauperism during the latter half of the 19th century. The effects of this association were still to be felt in the public attitude, however, well into the 20th century.

Also in the latter part of the 19th century, there began to appear a general recognition of the need for special hospitals in the larger cities for the treatment of acutely mentally ill persons. Since these persons usually were handled by the police as "drunk cases," medical attention for them was extremely difficult to obtain. Massachusetts showed the way in the establishment of the Boston Psychopathic Hospital which opened in 1912 with Dr. E. E. Southard as its director. Another name important in this

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milestone of community care of the mentally ill was that of the psychiatrist, Dr. L. Vernon Briggs. Although he had energetically campaigned for hospitals located in metropolitan centers for "first care" of the mentally ill, his name is more permanently attached to another accomplishment. This is the "Briggs Law" enacted in 1921 in Massachusetts which is both a model of the type of law used to better define criminal responsibility and is also a monumental example of the responsibility of the psychiatrist to his community.

The first decade of the 20th century witnessed a remarkable social phenomenon; that is, the wide-spread participation of citizens in the improvement of a variety of medical care programs. Appearing on the scene were numerous voluntary health organizations, among them the predecessors of many present day national voluntary health societies. It was in 1909 that the National Committee for Mental Hygiene, one of the parent bodies of the National Association for Mental Health, was born.

Changing Relations

Prior to World War II, psychiatry was practiced largely in state institutions and in private, profit and non-profit, institutions in the population centers of the country. During and following World War II, psychiatry attained added impetus through social pressure and community awareness. The sharp increase in the number of private practicing psychiatrists that followed has been a reflection and a part of this phenomenon. This movement of the practice of psychiatry from the institution into a close integral association with the community where the psychiatrist practices, as does any other physician, has brought him into a closer relationship to the problems of community mental health.

The example of leadership of the pioneers of the private practice of psychiatry in this area provides a pattern and ideal for us all. In Louisville, psychiatric units in three general hospitals have been established, a large non-profit psychiatric hospital has become an integral part of the community, and active participation on the volunteer faculty of the community medical school has been maintained. Also, through the joint efforts of the full-time psychiatric faculty of the medical school, the private practicing psychiatrists of the community, the State Department of Mental Health, and the Norton Memorial Infirmary, a psychiatric clinic for adults has been established.

In addition to this, psychiatrists are serving on the faculties of two theological seminaries; a school of social work; as active consultants to the juvenile court, as well as board members of the juvenile court; and consultants to children's agencies, as well as state agencies.

These are only a few of the examples of the extent of participation in community activity by our Louisville group, and I am sure similar examples can be given for the group in Lexington. I review these activities not only because of pride in my colleagues, but also to point out that one's influence goes not only through his professional contact but also through his active participation in the needs of special groups in his community.

Above all, the psychiatrist's role in community mental health is to practice the best quality of psychiatry. The scope of his influence is not quite known to him and many attitudes and opinions are generated as a result of his efforts, not only through his patients and their families, but also through referring physicians and agencies. Perhaps all too often we leave a referring physician in the dark as to what is going on and as to what contribution he can make to the patient's welfare. At the same time, I am occasionally frightened to see the finality with which a psychiatric consultation report is regarded by some referring physicians and social agencies.

Summation

The private practicing psychiatrist's role in community mental health is twofold. First, to provide diagnostic and treatment services for mental disorders within the medical community; and second, but not least, to assume a role of leadership in community problems and services where his special training and experience is of positive value. Not only psychiatrists, but also all practitioners of medicine, need to assume a role of leadership in helping their communities to work out problems of mental health and mental illness. The trend has started nation-wide. People are aware of the need and are going to do something about it. Let's make ourselves available through county and state medical societies to lend assistance to this—one of today's most pressing health problems.

Sudden, Unexpected Death in Infancy Pathology, Pathogenesis, and Possibility of Prevention†

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The anatomy, epidemiology and chemistry of infants who were "crib deaths" are described. Similarities between these anatomic lesions and those of anaphylactic origin are demonstrated. An hypothesis on pathogenesis and prevention is advanced.

THE term "Sudden, Unexpected Death" in infancy refers to deaths occurring in children who have ostensibly been asymptomatic and healthy. Such deaths have also been referred to as "crib deaths" "suffocation," etc. The problem is one of major medical importance because it claims the lives of about 20,000 infants a year. Exact information as to its frequency is virtually impossible to obtain, however, because "sudden, unexpected death" is not a legally permissible death certificate entry and, therefore, other disease processes are assigned as the cause of death. Perhaps a better idea of frequency can be obtained from the statistics for Jefferson County, Kentucky, where one of us (DS) is a Deputy Coroner and himself performs the postmortem examinations on infants and assigns the cause of death. In the county, which has a population of roughly 600,000, there were approximately 100 deaths of this nature in 1962. Personal communications from the Medical Examiners of Broward County, Florida and Los Angeles County, California, indicate that the incidence in those areas is of the same order.

The "disease" is one which has its peak incidence at three months of age; it is twice as common in boys as it is in girls, and in some areas there is a slightly increased incidence during the winter months.[1,2] Instances of more than one such death in the same family have been reported.[3]

Previous studies of the nature and causes of "Sudden Death" have been valuable only insofar as they have contributed negative data. No specific bacterial or viral agent has been recovered.[4] There are no gross anatomic malformations, although an occasional infant with small adrenals has been described,[5] and no abnormalities of blood chemistries have been found. Although the question of deficient immunity has been raised these infants have normal levels of gamma globulins, or even higher than normal levels.[6]

Current Studies

The present studies are based on work done at Children's Hospital of Louisville. During 1962-1963, 44 patients were referred to the pathology department by the Coroner's Office, Jefferson County, for postmortem examination. Included in the studies were only those infants who had no previous history of disease (by which is meant as far as could be determined there were no symptoms even of a minor nature) and concerning whom there was no indication of neglect or foul play as determined by the Coroner's investigation.

The basic observations were of an anatomic

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nature which in turn led to various chemical studies. The presentation, therefore, will be in that order. The single gross anatomic peculiarity consistently present in all children was an enlarged thymus. In a control series the average weight of the thymus at three months of age was 12 grams, but in the infants dying suddenly and unexpectedly the average weight was 29 grams. Although the weight of the thymus is more variable than most organs, the more than two-times increase and the fact that it occurred in all of the children dying suddenly and unexpectedly is significant.

Microscopically, alterations of structure are most apparent in the lungs and kidneys. In the lungs there is generalized overexpansion of the alveolar spaces associated with considerable quantities of edema and occasionally with petechial hemorrhages, apparently of recent origin. In the kidneys the lesion primarily affects the glomerulus. (Fig. 1) The capillary tuft is enlarged and Bowman's space is either obliterated or reduced in size. The outlines of the glomerulus are indistinct and occasionally swelling of the cells of Bowman's capsule is seen. Within the tuft itself there is hypercellularity caused by swelling of what are probably mesangial cells. (It has not been possible to obtain material early enough to have the degree of preservation necessary for electron microscopic studies). Swelling of cells within the tuft is accompanied by a decrease in number and size of capillaries and although usually one or two channels can be seen the glomeruli have a bloodless look. Histochemical studies of these glomeruli indicate a loss of integrity of the basement membrane. Actual necrosis or inflammation is rare but scarred glomeruli are found in approximately half the babies, indicating trauma at some time prior to death. The tubules generally show few changes but occasionally hyaline droplet formation within the cytoplasm of the proximal tubular epithelial cells can be seen. In some infants there has been calcification of the distal tubule in the region of the macula densa. In about half of the infants there is swelling of the walls of the arterioles.

Similar, though less dramatic, changes can be seen in the liver and spleen. In the liver, swelling and pallor of the liver cells is seen while in the spleen there is prominence of the arterioles, especially of the red pulp. In the thymus no obvious lesion is seen but there is a persistence of the fetal architectural pattern.

An observation of a negative character is that there is a paucity of eosinophils in the thymus, spleen and lymph nodes, and bone marrow.

The lesions described, especially the glomerular lesions, have been present in 100 per cent of infants dying suddenly and unexpectedly. Similar alterations are occasionally found in patients dying of other causes, notably those usually associated with hypersensitivity reactions.

Postmortem studies of the urine were carried out on fifteen infants. In all there was a significant (3-4 plus) albuminuria. Chromatographic analysis of the urine revealed a diffuse aminoaciduria, though whether this is of a significant degree or not is not known, and quite significantly the presence of an abnormal compound known as a "nephrosis peptide".[7] The nature of the nephrosis peptide is not known and previously it has been found only in the urine of children suffering with classical, essential nephrosis.

Discussion

The significant features observed at postmortem examination in children dying suddenly and unexpectedly:

1. Significantly enlarged thymuses.
2. Pulmonary edema and occasional petechial hemorrhage.
3. "Reactive" glomerulitis.
4. Albuminuria.
5. Presence of an abnormal peptide in the urine.
6. A pronounced peak of incidence at three months of age.
7. A variety of less dramatic anatomic alterations such as prominence of the arterioles of the spleen, swelling of liver cells and generalized absence of eosinophils in the tissues.

In those infants studied immediately after discovering the renal lesion, studies of blood urea nitrogen, serum electrolytes, serum proteins and gamma globulins were performed. Although the BUN in approximately half of the infants was elevated (30-35 mgs%) it was not at a level consistent with a death due to renal failure. In general, gamma globulin comprised 10 per cent of the total proteins and was in the range of about 0.65 gms/ml. This is slightly higher than the control normals but not significantly so. The observations on

gamma globulins are essentially the same as those recently reported by Valdes-Dapena,[6] et al.

From the nature of the anatomic lesions it appears that the disease mechanism most likely to produce these would be a hypersensitivity reaction,[8] or, being of such a severe degree, an anaphylactic reaction. Attempts were made to demonstrate antibodies to milk, and various bacterial proteins by agar-gel diffusion techniques and in none of the babies could a reaction be seen. In seven of the babies urinary studies prior to death were available. These were obtained through the state PKU testing program. The samples returned primarily for testing for PKU are, incidentally, tested for ten other substances including urinary proteins. Five of the infants had no albumin in their urine at the time of the test for PKU. Two infants had shown measurable amounts of protein. It is likely that the albuminuria so marked at the time of death is of intermittent occurrence.

In any analysis of the pathogenesis of sudden, unexpected death in infancy, all of these factors would have to be taken into account. Previous studies indicate that an infectious basis for this syndrome is most unlikely for no consistently recoverable microorganism or viral agent has been found. Further, because of the different rates of occurrence in the sexes it is unlikely that an infectious agent was the basis for this disease. Still further, inasmuch as the infant is increasingly exposed to the general population and the possibility of infection with advancing age, it becomes difficult to reconcile the peak incidence of the disease at three months of age with an infectious hypothesis.

When the physiology of the infant at three months is analyzed in detail there is one factor of singular importance. This is the disappearance from the infant's blood stream of the antibodies received passively from the mother. It would be desirable then, inasmuch as no other single factor can be related to this particular age, to relate this factor to the syndrome. If, however, a specific infectious agent is not the cause of sudden death what role could the maternal antibodies fulfill which, upon their disappearance might prove injurious to the infant's health? Although this reasoning is somewhat teleologic it again leads to the hypothesis that sudden death may in some respect be the result of an anaphylactic reaction caused by the disappearance of passively received, protective antibodies from the mother at a time when the infant is not able to manufacture sufficient antibodies of his own to neutralize the antigens.

Having two sets of observations, the anatomic and the physiologic, which tend to lead thinking in terms of anaphylaxis and antibody-antigen reactions in general, certain other features of the disease fall in place. The striking hyperplasia of the thymus, noted since late in the 19th century,[9] especially in the light of the recent advances made in relating the thymus to the instigation of immune processes in the body can be explained on the basis of the fact that these infants have excessive loads of antigen and require larger amounts of antibodies than other infants and the entire immunologic mechanism responds, the thymus specifically, in an anatomic sense of compensatory hyperplasia. The rather high levels of gamma globulin noted in this and other laboratories also indicate that there is an excessive production of these substances. The relative absence of eosinophils is compatible with a continuous or repeated stress reaction. The most critical questions, however, are: a) What is the antigen; and, b) How does it enter the body? The answer to the first is not known at the present time. But, because of the occurrence of the "nephrosis peptide" and the possibilities of determining its chemical nature and origin there is hope of identification of its source. As far as the means of entry of antigen into the body are concerned this is considerably simpler. It is known[10] that infants absorb some proteins through the gastrointestinal wall without alteration, i.e., egg albumin, blood plasma, etc. These proteins are generally not used by the body but are excreted, unchanged, through the urine. In the course of the state program for testing for phenylketonuria it has been found that approximately two per cent of all infants have albuminuria at the time of the single test, about 40 per cent of whom have more than a "trace". No symptoms have been noted to accompany albuminuria and it is probably the result of absorption of protein. Combining these two sets of data, approximately 0.8 per cent of infants absorb and excrete significant quantities of proteins from the gastrointestinal tract.

With this knowledge a reasonable hypothesis for the occurrence of sudden death can be advanced. About one per cent of all infants absorb significant quantities of unaltered proteins

from the gastrointestinal tract. Some of the proteins absorbed are antigenic. Protection against the reactions elicited by the antigenicity of these proteins is provided by passively received antibodies from the mother during approximately the first three months of life. With the disappearance of these passively received antibodies at a time prior to the development of full efficiency of the baby's own immunologic system the absorbed antigenic proteins for an indeterminate period of time are allowed to exert their actions unopposed. When, through the coincidence of exposure to proteins which can be absorbed at that moment in their existence when they are not protected by maternal antibodies the babies do absorb a significant quantity of antigen, an anaphylactic reaction results. What influences excessive absorption is not known. It is known, however, that alterations in the motility of the gastrointestinal tract alter absorption.[11] It is further known that the infant's gastrointestinal tract is notoriously variable in its motility, and it reacts to distant stimuli with a violence not seen in older individuals. Although infection of any significant degree has not been found to be a cause of sudden death in infancy, in many of the infants minor, microscopic, inflammatory lesions have been described. It is possible that although such lesions were of such minimal extent that they gave rise to no symptoms per se they nevertheless were sufficient to excite a generalized physiologic reaction in the infant, especially of the gastrointestinal tract.

Having arrived at such a conclusion the logical question is a pragmatic one best stated as "So what?" From the evidence presented infants liable to such a chain of events could be identified simply by continuous testing of their urine for the presence of albuminuria. At the present time, though expensive, for example it would be possible to place a paper strip in each clean diaper and observe a color change. In infants who manifest proteinuria on more than one occasion it would be desirable to adjust the diet so that none of the offending proteins were present, or to provide pharmacologic antidotes. That infants dying suddenly and unexpectedly do manifest proteinuria at one time or another prior to death is attested to by a singular instance provided to the author by a singularly qualified observer. The baby's mother was a board certified pediatrician who, for reasons not apparent to other observers, suspected that "something was wrong" with her child. After exhaustive investigation at an outstanding pediatric center the child was declared well. It had, however, been noted during the period of hospitalization that the child had an intermittent albuminuria and after discharge the mother, on four occasions, also tested for and noted albuminuria. The infant was found dead at the age of two months. Examination of the infant revealed anatomic lesions essentially as described above.

Conclusion

Sudden, unexpected death is essentially one of an anaphylactic nature. The cause of the anaphylaxis is a protein absorbed from the gastrointestinal tract. The absorption of this protein from the gastrointestinal tract is determined by three factors:

a. A physiologic defect in the infant which allows him to absorb unaltered protein.
b. The presence of the protein in the diet.
c. The occurrence of incidental events, i.e., infections, which might affect gastrointestinal motility and the probability of absorption of various substances from the gastrointestinal tract.

Because the infant absorbs antigenic proteins his immunologic mechanisms are worked to their fullest degree, as manifested by high levels of gamma globulin, and the organ responsible for the initiation of such mechanisms, the thymus, undergoes compensatory hyperplasia. Death results from anaphylactic reaction following insufficiency of neutralizing antibody as the result of the natural loss of passively received maternal antibodies. Infants susceptible to this type of death can be identified by the presence of intermittent albuminuria and by radiologic evidence of a large thymus. In theory it would be possible to remove the antigenic stimulus from the diet, or pharmacologically prevent these anaphylactic deaths.

Summary

1. Sudden, unexpected death in infancy is a medical problem of major proportions. It ranks as the tenth most common cause of death of all persons. Data, admittedly insufficient, indicates that such death occurs in one of every 200 infants.

2. The anatomic manifestations are diffuse emphysema of the lungs, pulmonary edema, occasional petechial hemorrhages; hyperplasia

of the thymus; swelling of glomerular tuft apparently due to edema of the mesangial cells occasionally associated with swelling of the arterioles and degeneration of the distal tubules; similar alterations are seen in the liver and spleen; there is an absence of eosinophils from their usual sites.

3. No infectious agents have ever been identified.

4. A finding present in every infant dying suddenly and unexpectedly is a massive albuminuria together with a chromatographically identified, abnormal substance known as a "nephrosis peptide".

5. The disease coincides with the disappearance of maternal antibodies from the infant.

6. The anatomic characteristics of the reaction are compatible with those seen in anaphylaxis.

7. The cause of the anaphylaxis is probably a protein absorbed from the gastrointestinal tract.

8. Infants susceptible to this type of death can be identified by the presence of intermittent albuminuria and radiologic evidence of an enlarged thymus.

9. Theoretically, infants who manifest albuminuria and an enlarged thymus could be identified and treated and such deaths could be avoided.

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Manuscripts should be submitted in duplicate to The Journal of KMA, an original copy and one carbon, and typed with double spacing. Maximum length of an article should not exceed 4500 words; the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

In submitting a manuscript, the author is requested to include a concise summary, not to exceed 35 words, to be used as a sub-title when the article is published in The Journal. The purpose of the summary is to create additional interest and encourage greater readership.

Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus published by the American Medical Association. This requires in the order given: name of author, title of article, name of periodical, with volume, page, month—day of month if weekly—and year. The Journal of the KMA does not assume responsibility for the accuracy of references used with scientific articles.

All scientific material appearing in The Journal is reviewed by the Board of Consultants on Scientific Articles. The editors may use up to six illustrations, with the essayist bearing the cost of all over three one-column halftones.

Arrangements for reprints of an article should be made directly with the publisher of The Journal, Gibbs-Inman Printing Company, 817 W. Market St., Louisville, Ky.

The bylaws of the Kentucky Medical Association provide that all scientific discussions and papers read before the KMA Annual Meeting shall be referred to the KMA Journal for consideration for publication. The bylaws further state that the editor or the associate editor may accept or reject these papers as it appears advisable and return them to the author if not considered suitable for publication.

Please mail your scientific articles to The Journal of the Kentucky Medical Association, 3532 Janet Ave., Louisville, Kentucky 40205.

SPECIAL ARTICLES

50 Years in The Practice of Medicine in Georgetown

HENRY V. JOHNSON, M.D.
Georgetown, Kentucky

THE following account, I trust, will not apppear egotistical, but simply a record to show how medicine and sanitation have advanced and improved in Georgetown in the last 50 years.

I was graduated from the Medical School of the University of Colorado in 1906 and served twelve months as an intern in the Denver and Rio Grande Railroad Hospital, where I was allowed to do a minimum amount of surgery. Doctor John Roe, who was afterward Chief Surgeon of the D. & R.G., and Doctor Connell, who originated the Connell intestinal sutures, were resident surgeons. They were two of the most skillful surgeons I ever saw.

Coming to Georgetown in September, 1907, I went to the office of Doctor John A. Lewis and Doctor W. H. Coffman. I borrowed $15 from my uncle, Judge George Payne, president of the Farmers' Bank, to buy a license to practice medicine. Doctor and Mrs. Coffman gave me my meals and a room over the office, otherwise I would have starved to death.

This was eight years before we built the John Graves Ford Memorial Hospital, and we operated in kitchens, bedrooms, dining rooms, etc. Doctor Scott, the City Health Officer, had just died and the City Board, composed of John Downing, Judge Thacker, and Ben A. Lair, Sr., appointed me as City Health Officer.

We had no filtration plant, and were pumping water out of the head of the spring. The water got low and we had a terrible epidemic of typhoid fever and lost many of our valuable citizens. On top of that, we had an epidemic of small-pox, and at one time I was treating 30 cases of this disease.

Doctor J. N. McCormack, State Health Officer and father of Doctor Arthur McCormack, came up to make an inspection. When he finished, he said, "Harry, it is not the fault of the spring, but the people who have built around it and are pouring their sewage into the branch." We ordered a vote to issue bonds and build a purification plant. It looked for a time as though the vote would not carry, but due to some influential men, it went over.

In 1920 we decided to have a full-time Health Department. We asked the Fiscal Court, composed of J. R. Lancaster, Fred Aulick, Tom Shuff, and Hedge True, to make the appropriation for $5,000, and the State was to put up the same amount. This was a very unpopular move, but due to our friends, the Court voted the amount. That was the start of the Scott County Health Department, which had now sold itself to the citizens of Scott County.

The next Fiscal Court refused to make the necessary $5,000 appropriation and allowed only $2,500; that was when our friends, headed by Mrs. Doctor Coffman, Anderson Brown and others, raised the other $2,500 and the unit continued. "Ma" Adams was one of the first Visiting Nurses and did a wonderful job for the people. She was second to Miss Hunt, who had been a nurse for the Health and Welfare Association. Doctor Coffman was chairman of the Board until his death in 1925. I then served as chairman of the Board until 1950, when I resigned to act as part-time Health Officer and allow the Fiscal Court to make the appropriation and Doctor Fred Wilt was elected chairman.

In addition to typhoid and small-pox, we had epidemics of influenza; the worst was in 1918. The infection was probably brought into Kentucky by the troops being sent from Texas to Port of Embarkation.

The first case I saw was a student from Hopkinsville who came to me with a temperature of 104 degrees. I put him in the hospital for a week and the next week I was down with it. The college students fell like the leaves from a tree. It spread all over town and many died from flu-pneumonia.

Whooping cough was the bane of my existence and many children developed bronchiectasis as a result. Diptheria antitoxin was in its infancy; many were afraid of it. They would postpone vaccination until a tracheotomy had to be performed.

An appendectomy was considered a most serious operation and it was, because most of the cases were diagnosed as "inflammation of the bowels", which of course they had after the appendix ruptured and peritonitis set in. I saw one case, with Doctor John A. Lewis, on whom Doctor Lewis did an end-to-end anastomosis. He lived about three days after the operation. I have always said there was never an appendix taken out too early, but many came out too late.

Following the flu epidemic of 1918 we had a number of cases of empyema; we resected a rib and put in a drainage tube with fairly good results.

Before we built the hospital, we did obstetrics under all sorts of conditions, with very poor help as a rule. The mothers had practically no prenatal care, and would often wait until the last minute to call a doctor. Feather-beds were a nuisance; sometimes it was hard to find the patient. The Cincinnati Enquirer was used instead of a rubber sheet, and why we did not have

more puerperal sepsis, I do not know.

Venereal diseases were quite prevalent, and were treated with Mercury, Potassium iodide and irrigation. We had no laboratory and patients were sent to Cincinnati for a Wasserman. There was no premarital examination or blood-test. Now we examine the couple, test their blood, wait three days, and then they may buy a license.

In 1908 we had only two Pasteur Institutes in the United States, and anyone bitten by a rabid animal had to go to New York or Chicago for treatment. I took one patient to Chicago, where he stayed for 21 days, getting a shot every day. Later on we sent our patients to Bowling Green, where the state laboratory was held for treatment. A man came into my office one day and asked me if I had a "Mad Stone". I had never heard of one, and he told me that you put it on the bite and if it turned green the animal was rabid. Maybe he was right.

"Ma" Adams and I used to examine the school children and it seemed to me that half of them were infected with the "Itch". We applied sulphur and lard and soon they were well. We also found *pediculosis capitis,* or head lice, but today that is a rarity. These good results are all due to education and more sanitary living conditions.

Infant feeding was one of our big problems. We tried to have the mother nurse the baby, but if that was not practical we hunted for a wet nurse. They were hard to find, and we turned to artifical feeding. Many babies were underfed and lost because of our lack of knowledge. The milk we give them today is a different product from the old formula.

Osteomyelitis was a rather common disease. I remember one boy who had an infection of the tibia; we operated several times and finally had to amputate above the knee. He got well and is now living in Georgetown and seems perfectly well.

Due to impure milk and water, summer diarrhea and "second summer complaint" kept us busy. This condition has now become rare.

Another trouble we had was malaria; mosquitos were quite prevalent and no one paid any special attention to them. We loaded the patients up on quinine until their ears rang. Measles, mumps, and tonsilitis were taken as a matter of course and treated accordingly.

Our method of transportation in those days was rather slow but sure. All of us drove horses and buggies. Some kept two horses; some kept three. When Maria and I married we lived on Jackson Street, and I kept my horse in the stable there. I rigged up a rope and pulley arrangement like the fire department used, so that I could raise the harness off the horse. When called at night I backed the horse under the shafts, dropped the harness and was ready to go, all in a few minutes. We had no paved streets, but had stepping stones at the corners and you had to hit them just right in muddy weather or it would almost throw you out of the buggy.

I have been president of the Scott County Medical Society and president of the Kentucky Midland Medical Society and Delegate from our county to the State Medical Association a number of times. I served for 12 years as secretary of the Scott County Medical Society. During that time we had a perfect record of meetings, once a month.

In 1909 we had no shortage of medical men in Scott County. There were two at Sadieville, two at Stamping Ground, one at Newtown, one at Minorsville, one at Payne's Depot, and plenty in Georgetown. Our fees were very small in the olden days; a house visit to a Negro was $1.00, to a white man, $1.50. Obstetrics was never over $25. Laparotomies $100 or less. My first year I grossed $300 and was out of balance 30 cents, which I have never caught up with.

Our experiences, in the early days, were varied, but there is one incident which stands out in my mind. A man died near Sadieville, and the family suspected poison and wanted his stomach analyzed. Judge H. C. Ford was County Attorney. Judge Ford, Mig Fleming, the Sheriff, and Oak Prather, the chauffeur, drove down and found the funeral about to begin. We took the body out of the casket put it on the kitchen table. I removed the stomach, sewed up the corpse, and the funeral went on.

In 1911 I began my postgraduate work, which started at the Post-Graduate Hospital in New York City. The next year I took a course at the Laboratory of Surgical Technique in Chicago. I went there three times, where we operated on live dogs, under anesthesia, and did everything from goiter to gall-bladders. Our clinics were held at the Augustana Hospital, which was founded by the Ochner Brothers. Later on, I went to the Mayo Clinic in Rochester and was there three times. In 1918 I volunteered in the Medical Corps of the U. S. Army and was sent to Fort Oglethorpe, Georgia, for training. I only served a short time and came home to practice again.

Doctor Coffman died in 1925. We then had a hospital, where Doctor D. B. Knox and I did most of the surgery. Doctor Knox was a skillful surgeon and was well thought of by his many friends.

Georgetown now has a modern hospital, with a fine laboratory, modern x-ray equipment, a most excellent director, and a corps of skilled nurses. We also have a water purification plant second to none, a most efficient full-time Health Department, responsible for sanitation, the immunization and examination of the school children. Our sewage disposal plant is preventing contamination of the water in Elkhorn Creek. Instead of 14 dairies, with milk unfit for human consumption, we now have sanitary dairies supplying us with good milk. Our Council members, headed by Mayor Harry Paxton, are serving the city and are always willing to hear constructive criticism. The Police Department, headed by Chief Billy Platt, is doing a wonderful job in protecting the interest of our citizens and controlling traffic. We have a Volunteer Fire Department, on the job 24 hours a day, and have not had a serious fire in years. Our grade schools, high schools, and the College have made wonderful improvements in the last few years.

We who have devoted our efforts to the improvement of our community during the past half-century find our reward—Georgetown is a beautiful city of the Bluegrass—and more, it is a safe and comfortable place to live and raise our families.

EDITORIALS

Thanks

THE Christmas Season provides the Editors of our Journal the opportunity to thank the many individuals for their scientific contributions and the companies that have supported the Journal by the purchase of advertising space, thus contributing to its success during the past year.

Among those to be thanked are the authors of the scientific and educational articles. The number of scientific articles submitted to the Journal for publication during the past year was sharply increased over previous years. In many instances the quality of the articles improved as well.

Many physicians and others throughout the Commonwealth have contributed special articles and news items that have helped the Journal serve its varied functions.

To the national and local companies and institutions that have used the Journal for advertising during the past year, the Editors wish to express their sincere appreciation and to offer the Season's Greetings.

Walter S. Coe, M.D.

In Flanders Fields * **

John McCrae

In Flanders fields the poppies blow
Between the crosses, row on row,
That mark our place; and in the sky
The larks, still bravely singing, fly
Scarce heard amid the guns below.

We are the Dead. Short days ago
We lived, felt dawn, saw sunset glow,
Loved and were loved, and now we lie,
In Flanders fields.

Take up our quarrel with the foe:
To you from failing hands we throw
The torch; be yours to hold it high.
If ye break faith with us who die
We shall not sleep, though poppies grow
In Flanders fields

* *(C) PUNCH, London*
** *This tribute is printed in memory of the 57 Kentucky physicians who passed away during the past year. See following page for complete list.*

Deceased Kentucky Physicians
1964*

F. T. Adams, M.D., Covington
John G. Archer, M.D., Prestonsburg
Alva Glenn Barton, M.D., Louisville
Charles K. Beck, M.D., Louisville
Maurice Bell, M.D., Eminence
John A. O. Brennan, M.D., Louisville
Beverly S. Broaddus, M.D., Irvine
C. C. Burton, M.D., West Liberty
William P. Cawood, M.D., Harlan
M. M. Collins, M.D., Lackey
J. W. Conway, M.D., Morganfield
Gilbert A. Cook, M.D., North Middletown
Vincent Corrao, M.D., Munfordville
Thomas J. Crume, M.D., Owensboro
Oscar T. Davis, M.D., Hopkinsville
G. P. Dillon, Jr., M.D., Louisville
Lester C. Dodson, M.D., Owensboro
F. J. Eakins, M.D., Robards
Raymond M. Evans, M.D., Louisville
Ernest M. Ewers, M.D., Somerset
J. E. Esteves, M.D., Warsaw
James W. T. Fuller, M.D., Mayfield
G. B. Froage, M.D., Paducah
Charles E. Gaupin, M.D., Louisville
Casey B. Graves, M.D., Morganfield
Edward P. Guerrant, M.D., Winchester
Harvey C. Hardegree, Jr., M.D., Louisville
Robert D. Higgins, M.D., Ashland
Emmet F. Horine, M.D., Brooks
William P. Humphrey, M.D., Sturgis
James G. Hutchinson, M.D., Louisville
William T. Jessee, M.D., Plummer's Landing
J. E. Johnson, M.D., South Williamson
M. M. Jones, M.D., Lexington
W. K. Kannard, M.D., Louisville
Robert E. Kennedy, M.D., Harlan
Earl Scott Lewis, M.D., Mouthcard
Emmett H. Miller, M.D., Vine Grove
Charlton A. Macpherson, M.D., Louisville
John C. Morrison, M.D., Hickman
John R. Nurse, M.D., Louisville
W. F. O'Donnell, Jr., M.D., Hazard
Albro L. Parsons, M.D., Louisville
Thomas A. Pease, M.D., Cunningham
Frank L. Peddicord, M.D., Louisville
Virgil L. Powell, M.D., Paducah
George Purdy, M.D., New Liberty
George L. Richardson, M.D., Adairville
Fred W. Rulander, M.D., Louisville
James A. Ryan, M.D., Covington
Perry C. Sanders, M.D., Danville
Leonard E. Stinson, M.D., Benton
Mack Whitis, M.D., East Bernstadt
C. A. Wood, M.D., Auburn
John P. Wyles, M.D., Cynthiana
Martin A. Yelton, M.D., Burlington
John P. Walton, M.D., Alexandria

** List of names of deceased physicians available to The Journal as of November 20, 1964.*

The A. D. Price Memorial Meeting of The Kentucky State Medicial Association

Terrace Room, Kentucky Hotel, Louisville, Kentucky, September 28-October 1, 1964

Digest* of Proceedings of the Regular Sessions of the

HOUSE OF DELEGATES

Garnett J. Sweeney, M.D., Liberty
Speaker of the House, Presiding

First Session

Doctor Sweeney called the meeting to order and asked Homer B. Martin, M.D., Louisville, to give the invocation. Norma Shepherd, M.D., Hopkinsville, a member of the Credentials Committee, reported that a quorum was present. It was moved and seconded that the minutes of the 1963 meeting be accepted as published in The Journal. The motion carried.

The KSMA Secretary, Henry B. Asman, M.D., presented the general announcements. He stated that the opening ceremonies for the general scientific session would begin at 9:00 a.m. Tuesday, September 29 at the Convention Center. Doctor Asman announced that Charles Jarvis, D. D. S. of San Marcos, Texas would be delivering the address at the President's Luncheon on Wednesday, September 30.

The Secretary read the list of physicians who had died since the 1963 meeting and the House stood for a moment in silence in their memory. The names of the physicians, their location and date of death are as follows:

Adams, F. T., Covington, August 1964
Archer, John G., Prestonsburg, July 4, 1964
Beck, Charles K., (Emeritus), Louisville, January 25, 1964
Bell, Maurice, Eminence, August 26, 1964
Brennon, John A. O., Louisville, Sept. 1, 1964
Brewster, Glenn W., Hustonville, (In Cincinnati), Dec. 5, 1963
Broaddus, Beverly S., (Emeritus), Irvine, Jan. 16, 1964
Burton, C. C., West Liberty, May 31, 1964
Clark, Edgar R., Louisville, Nov. 24, 1963
Collins, M. M., (Emeritus), Lackey, Jan. 24, 1964
Combs, Pearl B., Dwarf, (Out of State), Nov. 3, 1963
Conway, J. W., (Emeritus), Morganfield, May 16, 1964
Corrao, Vincent, Munfordville, August 1964
Cosby, Ira D., (Emeritus), Henderson, Nov. 9, 1963
Crume, Thomas J., (Emeritus), Owensboro, Apr. 26, 1964
Davis, Oscar T., Hopkinsville, Aug. 11, 1964
Dillon, G. P. Jr., Louisville, Aug. 16, 1964
Dodson, Leslie C., Owensboro, July 21, 1964
Eakins, F. J., Robards, July 1964
Ellis, Stephen R., (Member), Louisville, Dec. 1, 1963
Evans, Raymond M., (Emeritus), Louisville, Apr. 15, 1964
Ewers, Ernest M., (Emeritus), Somerset, 1964
Esteves, J. E., (Member), Warsaw, Sept. 20, 1964
Froage, G. B., Paducah, July 31, 1964
Gaupin, Charles E., Louisville, March 21, 1964
Graves, Casey B., (Emeritus) Morganfield, Nov. 16, 1963
Guerrant, Edward P., Winchester, June 17, 1964
Hall, John C., Ashland, Oct. 18, 1963
Hardegree, Harvey C. Jr., (Member), Louisville, September 8, 1964
Harrell, J. F., Bardwell, (Out of State), August 1964
Hodges, Stuart, Alva, (Out of State), Oct. 6, 1963
Horine, Emmet F., (Emeritus), Brooks, Feb. 1, 1964
Hoskins, Albert B., (Emeritus), Beattyville, Dec. 9, 1963
Hutchinson, James G., (Emeritus), Louisville, Apr. 30, 1964
Johnson, J. E., South Williamson, July 20, 1964
Jones, Beverly P., Barbourville, Nov. 28, 1963
Kannard, W. K., Louisville, September 16, 1964
Kennedy, Robert E., Harlan, January 1964
Kimber, Karl E., Ashland, Oct. 26, 1963
Lawrence, Marshall M., (Member), Jamestown, Oct. 9, 1963
Lewis, Earl Scott, (Member), Mouthcard, June 23, 1964
Meece, Grover C., (Member), Whitley city, Oct. 16, 1963
Miller, Emmett H., Vine Grove, Mar. 11, 1964
Morrison, John C., (Member), Hickman, June 10, 1964
Neblett, Lamar W., (Member), Louisville, Oct. 24, 1963
Nurse, John R., Louisville, Aug. 6, 1964
Owens, Walker, (Emeritus), Mt. Vernon, Dec. 5, 1963
Pauli, Augustus J., (Member), Louisville, Dec. 18, 1963

Editorial Note: A tape recording was made of the two sessions of the House of Delegates, and any member who desires to examine the transcript of the proceedings, may come to the headquarters office and listen to the recording.

Peddicord, Frank L., (Emeritus), Louisville, Apr. 9, 1964
Raike, Ellis E., Greenup, Nov. 2, 1963
Richardson, George L., (Member), Adairville, Apr. 22, 1964
Robbins, Ballard F., (Member), Berea, Nov. 4, 1963
Rulander, Fred W., Louisvlle, July 28, 1964
Ryan, James A., Covington, Jan. 18, 1964
Sanders, Perry C., Danville, September 10, 1964
Scrivner, Samuel T., (Member), Stanton, Oct. 30, 1963
Stambaugh, Harry G., Ashland, (Out of State), Nov. 30, 1963
Stinson, Leonard E., Benton, September 2, 1964
Weber, Jacob, (Emeritus), New Albany, Ind., Nov. 26, 1963
Whitis, Mack, East Bernstadt, May 24, 1964
Wood, C. A., Auburn, Aug. 13, 1964
Wyles, John Peter, Cynthiana, Jan. 20, 1964
Yelton, Martin A., Burlington, June 30, 1964
Zinn, Newton G., Alexandria, Dec. 8, 1963
Walton, John P., (Emeritus), Central City, September 22, 1964
O'Donnell, W. F., Jr., (Member), Hazard, September 24, 1964

The Speaker announced the reference committee appointments as follows:

Reference Committee No. 1—Reports of Officers and Board of Trustees

Ballard W. Cassady, M.D., Pikeville, Chairman
Glenn W. Baird, M.D., Bandana
Walter L. Cawood, M.D., Ashland
Paul J. Ross, M.D., Louisville
George H. Widener, Jr., M.D., Paducah

Reference Committee No. 2—Scientific Assembly and Medical Education

W. Gerald Edds, M.D., Calhoun, Chairman
Richard A. Allnutt, M.D., Covington
Walter O'Nan, M.D., Henderson
Robert A. Orr, M.D., Mayfield
Samuel D. Weakley, Jr., M.D., Louisville

Reference Committee No. 3—Legislative Activities

Homer B. Martin, M.D., Louisville, Chairman
Harold B. Barton, M.D., Corbin
M. C. Loy, M.D., Columbia
James G. Sills, M.D., Hardinsburg
David B. Stevens, M.D., Lexington

Reference Committee No. 4—Public Service and Allied Professions

Paul H. Klingenberg, M.D., Covington, Chairman
William E. Becknell, M.D., Manchester
Andrew M. Moore, M.D., Lexington
Paul J. Sides, M.D., Lancaster
B. H. Warren, M.D., Owensboro

Reference Committee No. 5—Medical Service

David W. Kinnaird, M.D., Louisville, Chairman
Walter L. Boswell, M.D., Lexington
Carl J. Brueggemann, M.D., Covington
David D. Drye, M.D., Bradfordsville
Claude C. Waldrop, M.D., Williamstown

Reference Committee No. 6—Constitution and Bylaws; Special Committees

N. Lewis Bosworth, M.D., Lexington, Chairman
J. S. Baughman, M.D., Harrodsburg
Donald Graves, M.D., Frenchburg
Ralph D. Lynn, M.D., Elkton
Henry W. Post, M.D., Louisville

Reference Committee No. 7—Miscellaneous

L. F. Beasley, M.D., Franklin, Chairman
W. B. Haley, M.D., Paducah
Charles E. Peck, M.D., Russell Springs
Joseph Saunders, M.D., Lexington
Hylan H. Woodson, M.D., Greenville

Doctor Sweeney announced that the tellers for the meeting would be M. R. Gilliam, M.D., Lexington; B. B. Baughman, M.D., Frankfort; W. C. Gettelfinger, M.D., Louisville; and Russell L. Hall, M.D., Prestonsburg.

The Speaker stated that alternates might be needed to serve on the reference committees when they convened at 2:00 on Monday, September 28 on the fourteenth and fifteenth floors of the Kentucky Hotel. He asked that the following physicians should they desire to fill possible vacancies to be on the fifteenth floor of the Kentucky Hotel at 2:00 that afternoon:
Owen Davis, M.D., Scottsville
M. J. Evans, M.D., Middlesboro
Ralph Cash, M.D., Princeton
Robert T. Longshore, M.D., Covington
Gene T. Watts, M.D., Hindman
J. C. Cantrill, M.D., Georgetown
J. M. Stevenson, M.D., Brooksville
T. R. Bryant, Jr., M.D., Lexington
Mary Pauline Fox, M.D., Hazard

Doctor Sweeney also announced that the KSMA Delegates and Alternate Delegates to the AMA had been assigned to the KSMA Reference Committees and would be serving as resource people during the committee hearings.

The reports of the officers and committees were presented at this time and referred to the respective reference committees by the Speaker as follows:

Report of the President—Reference Committee No. 1

Report of the President (Page three numbered paragraph two and the numbered paragraph seven on page four)—Reference Committee No. 2

Report of the President, Woman's Auxiliary to KSMA—Reference Committee No. 1

Report of the President-Elect—Reference Committee No. 1

Report of the Speaker of the House—Reference Committee No. 1

Report of the Chairman, Board of Trustees—Reference Committee No. 1

The Speaker then recognized William Bizot, M.D., the chairman of the Awards Committee, for his nominations for the Distinguished Service Medal, and the Outstanding General Practitioner Award. G. L. Simpson, M.D., Greenville, was nominated for the Distinguished Service Medal. A motion was made, seconded and carried that Doctor Simpson be the recipient of this award.

Doctor Bizot then placed the name of Lloyd M. Hall, M.D., Salyersville, in nomination to be the recipient of the Outstanding General Practitioner Award. The motion was seconded and carried.

The Speaker of the House then introduced Mrs. Bettye Fisher of Evansville, Indiana, a past president of the American Association of Medical Assistants. Following the brief address by Mrs. Fisher, which was well received, the House recessed for fifteen minutes. The Kentucky State Association of Medical Assistants provided coffee.

After reconvening the House, Doctor Sweeney continued with the assignment of the reports to the various reference committees as follows:

Report of the Secretary—Reference Committee No. 1

Report of the Editor—Reference Committee No. 1

Report of the Treasurer—Reference Committee No. 1

Report of the Delegates to the AMA—Reference Committee No. 1

Report of the Executive Secretary—Reference Committee No. 1

Report of the Council on Scientific Assembly—

Reference Committee No. 2

Report of the Council on Medical Education and Hospitals—Reference Committee No. 2

Report of the Council on Legislative Activities——Parts I and II—Reference Committee No. 3

Report of the Council on Medical Services—Reference Committee No. 5, except that the entire report of the Medical Discipline Committee on page 3 including its nine recommendations and the proposed amendments to the KSMA Bylaws beginning on page 19 will be referred to Reference Committee No. 6

Report of the Council on Communications and Public Service—Reference Committee No. 4, except that on page 6 numbered paragraph 10 and the Board action on page 17 will be referred to Reference Committee No. 3

Report of the Council on Allied Professions and Related Groups—Reference Committee No. 4, except that fifth and sixth paragraphs on page 3 of this report will be referred to Reference Committee No. 3.

Report of the Advisory Committee to the Editor—Reference Committee No. 6

Report of the Professional Relations Committee—Reference Committee No. 6

Report of the Committee on Third Party Medicine —Reference Committee No. 6

Report of the Committee to Study the Constitution and Bylaws—Reference Committee No. 6

The Speaker of the House recognized James M. Riley, M.D., chairman of the Jefferson County Delegation. Doctor Riley stated that the Jefferson County Delegation was submitting an amendment to the Report of the Committee to Study the Constitution and Bylaws dealing with indoctrination. Doctor Sweeney referred this amendment to Reference Committee No. 6.

Report of the Interim Meeting Program Committee—Reference Committee No. 6

Report of the Insurance Review Board—Reference Committee No. 6

Report of the Board of Directors, Kentucky Physicians Mutual, Inc., Reference Committee No. 5

The Chairman of the Medical Services Committee, Doctor Pierce, read the addendum to the report of the Board of Directors of Kentucky Physicians Mutual, and the Speaker of the House referred this to Reference Committee No. 5.

Report of the Board of Trustees, Rural Kentucky Medical Scholarship Fund, Reference Committee No. 5

Report of the McDowell Home Committee—Reference Committee No. 7, except the third paragraph on page 4 beginning with the words "it is a matter of pride . . ." and the attached financial report will be referred to Reference Committee No. 1.

Report of the Memorials Commission—Reference Committee No. 7

Report of the Technical Advisory Committee on Indigent Medical Care—Reference Committee No. 5

Report of the KSMA Representative to Conference of Presidents and Other Officers of State Medical Associations—Reference Committee No. 7

Report of KSMA Representative, U. of K. Chapter, Student AMA—Reference Committee No. 7

Report of KSMA Representative, U. of L. Chapter, Student AMA—Reference Committee No. 7

Report of KSMA Representative on Kentucky Poison Control Program—Reference Committee No. 6

Report of the Advisory Committee to Selective Service—Reference Committee No. 5

Report of Representative, Advisory Committee on Maternal and Child Health, State Department of Health—Reference Committee No. 7

Report of the Representative, Kentucky Mental Health Planning Commission—Reference Committee No. 5

New Business

The new business was then presented to the House and referred to the reference committees by the Speaker as follows:

(A) Resolution of KSMA Committee on Disaster Medical Care concerning Hospital Signs on Highways—Reference Committee No. 5

(B) Resolution of Muhlenberg County Medical Society on the subject of Social Security Coverage for Physicians—Reference Committee No. 3

(C) Resolution of Jessamine County Medical Society concerning Straight Internships vs. Rotating Internships. J. S. Williams, M.D., the delegate from Jessamine County submitted a correction in the first resolved of the resolution substituting the word "exclusively" for "per se". The Speaker of the House referred this resolution as corrected to Reference Committee No. 2.

(D) Resolution of Campbell-Kenton County Medical Society on the subject of Private Hospital Internships—Reference Committee No. 2

(E) Resolution of Campbell-Kenton County Medical Society concerning Appointment of Dr. E. Annis, M.D.—Reference Committee No. 1

(F) Resolution of Campbell-Kenton County Medical Society relating to Participation in New Third Party Plans—Reference Committee No. 5

Doctor Sweeney recognized Wyatt Norvell, M.D., New Castle, AMA Delegate, who presented the following resolution to the members of the House:

WHEREAS, Norman A. Welch, M.D. died in Wyoming while carrying out his official duty as President of the American Medical Association,

WHEREAS, he had so well and unselfishly devoted his God-given abilities and attributes of leadership as Speaker of the House of Delegates, President-Elect and for such a short period of time, as President of the American Medical Association,

WHEREAS, he so well exemplified in deeds his own words as expressed in his inaugural address that medicine must be united "to serve the public in the future to the high degree that it has in the past"

WHEREAS, he had for many years been active in financing medical care for the people of his home state and distinguished himself both as a member of the Board and as President of the National Conference of Blue Shield Plans,

WHEREAS, Norman A. Welch, M.D. was truly a worthy example of Robert Louis Stevenson's "A Tribute to a Physician", and,

WHEREAS, he will be sorely missed by his many local friends in Kentucky,

THEREFORE, NOW BE IT RESOLVED that the members of this House of Delegates record its grief on the passing of this great American physician and express its warmest sympathy to his lovely and loyal wife and to his children.

The members of the House of Delegates adopted this resolution by a standing vote.

The meeting places for the Nominating Committee for general officers and the six Trustee Districts were announced by the Executive Secretary. He stated that the Nominating Committee would report immediately at the close of the first scientific session on Tuesday morning at the Convention Center, and these nominations would again be read at the second meeting of the House on Wednesday, when according to the Bylaws, additional nominations could be made from the floor without discussion or comment.

With there being no further business, the meeting adjourned at 12:15 p.m.

Second Session

The second session of the House of Delegates was called to order on September 30, 1964 by the Speaker Garnett J. Sweeney, M.D. E. C. Seeley, M.D., London, gave the invocation.

The Chairman of the Credentials Committee, Harvey Chenault, M.D., reported that a quorum was present.

The Speaker recognized the Chairman of the Board of Trustees, Douglas E. Scott, M.D., who presented the final report of the Board of Trustees as follows:

The Board of Trustees submits the following resolution, passed at its September 30 meeting:

"WHEREAS, the 1964 KSMA Annual Meeting has made a substantial contribution in the field of continuing medical education and its program has been well received, and

"WHEREAS, many individuals, organizations, and agencies including our guests and the essayists from our State, the scientific and technical exhibitors, the sponsors of the Message Center, the newspapers, radio and television stations, the hotels, and the Convention Center, have contributed greatly to its success, and

"WHEREAS, the Trans-Atlantic CPC sponsored by Smith, Kline and French has again made a fine contribution to our meeting, now

"THEREFORE BE IT RESOLVED, that this House of Delegates goes on record as expressing its deepest appreciation to all individuals and organizations who have had a part in the development and implementation of the 1964 Annual Meeting."

Doctor Scott moved the adoption of the resolution. The motion was seconded and carried.

Doctor Asman presented the announcements. He recognized O. B. McGillicuddy, M.D., Lansing, Michigan, president of the Michigan State Medical Society and E. A. Piszczek, M.D., Chicago, president of the Illinois State Medical Society.

The reports of the Reference Committees were then presented.

† *In order to make the Digest of Proceedings of the second meeting of the House of Delegates more understandable and because it will occupy less space in The Journal, the KMA Board of Trustees passed the following motions "That if no dissenting action on the committee's recommendations is made either by the Council under which the committee serves or the KMA Board of Trustees, only the reference committee action on the report be printed in The Journal."*

REFERENCE COMMITTEE NO. 1 †

Ballard W. Cassady, M.D., Chairman

Reports of Officers and Board of Trustees

Reference Committee No. 1 considered the following reports:

1. Report of the President
2. Report of President, Woman's Auxiliary to KSMA
3. Report of President Elect
4. Report of Speaker of the House
5. Report of Chairman of Board of Trustees
6. Report of the Secretary
7. Report of the Editor
8. Report of the Treasurer
9. Report of the AMA Delegates
10. Report of Executive Secretary
25. Report of the McDowell Home Committee

Resolution E — Appointment of Dr. E. Annis, M.D.

Report of the President

One of the major objectives of my administration has been to communicate to each member of the Association as clear an understanding as possible of what his KSMA is doing for him in all of the various areas of activity, scientific, economic and political. We have an organization we can be proud of.

If any one of you wants to take issue with that statement, we would urge you to carefully review each of the approximately 225 pages in our House of Delegates folders, which relate to the sixty-odd reports submitted by our officers, Board, and councils and committees. Then, we are convinced, you will agree with me that we have had an excellent year in KSMA.

It will not be possible here to mention progress on all the various fronts during the past year; however, we would like to mention a few.

We have, at this writing, the largest number of paid members in the history of KSMA, despite the increase in dues last year. We are encouraged by this growth, but we must find ways to increase interest in our organization. All active physicians should be supporting the ideals and programs of organized medicine.

Another fine accomplishment of KSMA is the activation of the Insurance Review Board, approved at the last meeting of the House of Delegates. This Board has a great potential of service in assisting the insureds, physicians, and insurance companies in areas of disagreement.

The KSMA Committee on Medical Discipline has, after two years of study, come up with a recommendation for the formation of a Judicial Council. We urge you to study this proposal, which you will be asked to pass on, carefully. It is most important in the life of our profession.

A new area of service was entered this year when KSMA sponsored the first Conference on Mental Health. This was a very successful meeting and should become more productive in the future.

We have had a very good year in the 1964 Kentucky Legislature. The functioning of the Kentucky Legislative Key-Man System was increasingly effective. We are told there is still room for progress. We were delighted to see the Board of Trustees pass a special resolution commending our legislative leaders for their good work.

At the time this report is written the fate of the Administration's efforts to pass compulsory medical

care for the aged through social security, which passed the Senate, is yet to be determined. Representatives of your state society have journeyed to Washington on three different occasions in this connection during the year, including KSMA's Annual Dinner honoring its senators and congressmen. To all those who have worked so diligently to keep our senators and congressmen informed on this issue so vital to the public welfare, we want to express our deepest appreciation.

We could go on and on. However, before we turn to other matters, we would like to acknowledge the work of our Committee on Disaster Medical Care and the Highway Safety Committee for their efforts in working with state governmental agencies in developing programs in the public interest.

Your President has had a busy year, too. We have left the state to attend seven meetings on behalf of KSMA. During the year we have given approximately 20 speeches, 14 of which were before KSMA Trustee districts. We have attended four meetings of the KSMA Board of Trustees, six meetings of the Executive Committee, and more than a dozen other KSMA committee meetings and meetings of other types sponsored by KSMA.

This year, that you have given me the honor of serving as your President, climaxes 15 years of serving in the ranks of your Associaton. During this time we have seen KSMA mature and become an active and influential force in many areas of endeavor in our state. You have consistently placed people in responsible positions that are knowledgeable and that have provided you with good leadership.

This is most fortunate for us all. Whether we like it or not, our responsiblities as physicians and as a medical organization have been projected into fields never before recognized by medicine as obligations. We must keep our position of leadership in health matters not only in the area of treating the sick, but as they relate to political and socio-economic developments.

To help maintan and extend our leadership and influence, I would like to make for your consideration the following recommendations:

1. That all county medical societies schedule at least one meeting a year for the purpose of communicating to its members developments in medical organization work of such interest to them. We urge the use of the following sources—KSMA officers, AMA delegates or alternates, and members of the KSMA Headquarters Staff to assist you.

*2. A growing movement in the Area Hospital Planning. This has a great potential for public service, if appropriately guided and kept on a voluntary basis. We must resist all efforts to make it a compulsory movement. We specifically recommend KSMA participation at every opportunity.

3. There have been many recent developments in Third Party Medicine. Good medical care must be provided to our people. Prevention of exploitation of both the public and the profession is our responsibility. We urgently recommend that KSMA use its best and most experienced talents in this area.

Note: This item was referred to Reference Committee No. 2.

4. Obviously, we must be looking for young physicians who are willing and able to be trained to assume positions of responsibility in KSMA. Moreover, we must not overload experienced men who can and do accept responsibility in KSMA. We will urge, therefore, that the Board of Trustees, the appointing authority, limit the appointment of each member to one position as a matter of general policy. There are a very few limited cases where this is not in the best interest of KSMA. The Board will judge these.

5. Medicine is a jealous mistress. This does not excuse us from cooperating more closely and enjoying the best of relations with the allied professions. We specifically recommend that the Board of Trustees provide the leadership in the appropriate committees to explore ways wherein there can be more cooperation with, and greater assistance to, our allied professions.

6. Articulate and aggressive minorities, often well financed and with smart leadership, are becoming more effective in influencing health legislation not in the public interest. The need for the selection and election of congressmen and senators inbued with the principles of the American Free Enterprise System is more compelling than ever. We urge your continued support of and membership in the Kentucky Educational Medical Political Action Committee.

*7. Our Hospital Committee and each individual doctor must take time to inform the many new and old hospital trustees throughout the state of their responsibilities, question them on what kind of job they think they are doing, and do they feel generally satisfied with their policy formulation in their boards. Subjects to talk on are: (1) trustee orientation, (2) trustee education, (3) board/medical-staff relationship, (4) hospital-personnel relationship, (5) public relations, (6) community relations.

May I make an urgent plea now for you as delegates from our 120 county medical societies—the very backbone of medical organization in Kentucky—to return to your county societies and faithfully and fully report the work and actions of this House of Delegates. You have, indeed, a great opportunity.

The many splendid accomplishments this year are the product of what we might call "KSMA team effort." So first, I would like to express my deep appreciation to the official family of KSMA—this includes the vice presidents, other officers, officials of the House and the Board of Trustees and the Councils and Committees—for their superb efforts. In this we would like to include the leadership of KEMPAC. We are very proud of the work that has been done.

And, of course, behind the scenes in all of this is our Headquarters Staff. Without it, little if any of what has taken place would have been accomplished. I am grateful to each member of the staff for his support.

George P. Archer, M.D., President
Kentucky State Medical Association

Note: This item was referred to Reference Committee No. 2.

Recommendations, Reference Committee No. 1

The Report of the President, with the exceptions of numbered paragraph 2, page 3 and numbered paragraph 7, page 4 was reviewed and is a summary of the activities of the President with suggestions for future action by the Society. The Committee recommends approval and acceptance of this report.

We also wish to commend our President for a job well done and express our appreciation for his efforts.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded and carried.)

Report of President, Woman's Auxiliary to KSMA

This year Kentucky reached two milestones: a phenomenal growth in membership to 1,516 and a visit with each county auxiliary by the state president or president-elect, usually by both. Our trips enabled us to call on potential members-at-large to "sell" Auxiliary. This visiting combined with the un-

ceasing efforts of the membership committee, other interested members, and the county auxiliaries added 151 more members than we had last year.

We encouraged active participation by members-at-large. Ten such members were on the state board as president-elect, councilors, and committee chairmen. Others taught baby-sitting, worked on health careers, made Johnny coats (hospital gowns from men's discarded shirts), participated in legislative activity, and assisted with membership. In several instances auxiliaries invited members-at-large from surrounding counties to their meetings, demonstrating the friendliness we found everywhere.

Emphasis remained on tailoring the program to fit the auxiliary's interests and its community's needs. Four issues of "Blue Grass News" carried information from state officers and chairmen and reports from county presidents. As individuals, doctors' wives touched every facet of community activity; as organizations, the auxiliaries participated in varying degrees in programs suggested by National. The summation of achievements in this report does not reflect the enormous contribution of service by individuals.

Intensive information was disseminated about AMA-ERF and various methods for securing contributions and raising money, paving the way for future increased use of such techniques.

Interest in civil defense resulted in donations to a local rescue squad, programs for self-education, representation at meetings, and offers of service. One auxiliary sponsored a civil defense first-aid course for members of Health Career clubs and one for itself. (Since 1960 that county's chairman has taught eight classes in civil defense for civic organizations.)

Broad-based and kaleidoscopic, community service projects truly reflected local interests and community needs: health education and fund-raising drives, immunization programs, diabetes detection, audiometric testing, cancer research, glaucoma screening, blood banks, blood mobiles, youth fitness, and medical quackery. Auxiliaries gave volunteer service or other aid to hospitals, a home for the aged, a penal institution, schools for the handicapped and retarded, flood relief, Girl Scouts, and underprivileged children. One group volunteered its services to an industrial commission seeking to attract new industry to the area by offering to entertain wives of visiting industrialists and acquaint them with local assets.

Nine auxiliaries have loan or scholarship funds for health careers. The state auxiliary currently has two students using its loan fund. Efforts to interest students in health careers were made through career clubs, career days, films, speakers, literature, sponsorship of candy-striper programs, training of practical nurses, and teas and tours for students of nursing. One auxiliary helped furnish a rooming-house provided rent-free by a group of doctors to medical students with financial need, while another helped furnish a lounge at a school of nursing. The state chairman compiled information about health career scholarships and loans available in Kentucky and sent it to each high school in the state.

Participation in international health activities increased. Fourteen auxiliaries donated one or more of the following: sample drugs, bandages, thermometers, surgical scissors, medical books, and Johnny coats. One group extended international hospitality by inviting wives of foreign doctors in its community to be "social members" and another continued last year's interest in families of foreign doctors in its midst.

Each auxiliary and member-at-large were urged to offer assistance for "Operation Hometown." One auxiliary had three letter-writing coffees. It also encouraged people to hear Doctor Annis when he spoke in the area. At each meeting, many groups had reports on pending legislation, although only three had programs on the subject. One group assisted in every way with the passage of a county health tax.

Eight auxiliaries had programs on mental health, three showing "A Cry for Help." One provided clerical assistance at a monthly mental health clinic, while others donated money, clothing, toilet articles, and toys to mental health institutions or projects. (Profits from a style show netted over a thousand dollars for mental health!) Two auxiliaries sponsored students at a state facility for mentally retarded, providing gifts, spending money, letters, and visits.

Special efforts were made for proper usage of seat belts by members of the state and local boards. A survey indicates that 56% use them all the time, 30% use them only on trips, while 14% still do not have them. A physician discussant showed the film "Broken Glass" at Fall Conference. Three counties sponsored GEMS projects (baby-sitting courses).

The By-laws Committee has worked seriously and thoughtfully making editorial changes in the Constitution and By-laws for purposes of clarification and conformity with present practices. Actual changes in meaning or procedures will be presented for action by the Convention, with a proposal that the Constitution and By-laws be reprinted as amended.

For the ninth consecutive year a health citation award will be presented at the Annual Meeting to a lay person or organization for an outstanding contribution in the field of health. Nominations for the award are made by county auxiliaries and members-at-large.

In the words of three county presidents, "We have worked hard, but we have had fun, too"; "We have accomplished the greatest objective of all—improving relations among doctors' families"; and "In general, we have tried to be of service to our communities and a credit to our husbands' profession".

The Auxiliary has been blessed in having a sympathetic parent organization that has understood our problems, shared our hopes, guided our efforts, praised our accomplishments, and contributed to our financial support. Officers, trustees, members, staff —all have consistently helped us with their kindness, their patience and their interest. Their acknowledgement of our efforts made us strive for even greater goals.

Mrs. J. Murray Kinsman, President
Woman's Auxilary to KSMA

Recommendations, Reference Committee No. 1

This report was reviewed by the reference committee and is a resumé of the excellent work by our Woman's Auxiliary. This committee wishes to recommend acceptance of this report and to commend Mrs. Kinsman and her Auxiliary members for a job well done.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Report of the President-Elect

The President-Elect is, upon election, a member of the Executive Committee of the Board of Trustees and a member of the Council on Scientific Assembly. Until one serves on the Council on Scientific Assembly, he has no idea of the work and effort that goes into preparation of the scientific program for an Annual Meeting. These people deserve much credit and get little for bringing together such a fine program as we have had for this year and for the arrangements for meeting in the New Convention Center. The activities of the Executive Committee and the Board of Trustees will be given by the chairman of the Board.

The President-Elect attended two meetings of the National Association of the Blue Shield Plans. Hundreds of great physicians have donated their time and efforts for a good many years for the development of this great movement. Blue Cross and Blue Shield have been our chief weapons with which to

fight Government intervention. They must be protected, improved, and preserved.

The President-Elect served on a special "Committee to Study the Activities of the Appalachian Regional Hospitals, Incorporated." This is mentioned only to call your attention to the importance of reading the report which will be given elsewhere. The very essence of private, competitive medical practice and ethics are involved. Your best will be called upon to decide some of these matters.

Only one speech of importance was made by the President-Elect and that was to a regional group of the "Student Branch of the American Pharmaceutical Association," which was held in Lexington. These people are eager to be friends of the physicians and they will be a source of great assistance when such is needed.

The annual Washington dinner for the Kentucky Senators and Congressmen was attended for the first time. This too will be reported elsewhere, but to the President-Elect, it appeared to be highly successful and well worth the time and expense.

Your President-Elect looks forward to serving the Association as it's President and anticipates hard work, cooperation and success for the coming year.

Delmas M. Clardy, M.D.
President-Elect

Recommendations, Reference Committee No. 1

The committee reviewed the Report of the President Elect, which was a resumé of his activities for the past year and they recommend acceptance of this report and pledge their wholehearted support to Doctor Clardy for the coming year.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded and carried.)

Report of the Speaker of the House

We wish to urge every Delegate to be aware of his responsibility in helping to shape the future of Kentucky Medicine.

Guide lines for ethical operation of various types of medical services are forged here. Full participation in reference committee discussions is desirable so that mature judgment might prevail before resolutions and recommendations are presented to the House at it's second meeting.

Your Speaker is eager to see a greater degree of unity develop in all of the elements of the medical community. As he carefully reviewed his list of Delegates to KSMA for 1964, he was disturbed to note, as far as he was able to tell, not a single full-time faculty member of a medical school was a Delegate. He would urge counties having medical schools to give this full consideration in 1965.

Remember, DELEGATE, your voice can and should be heard.

Attend Reference Committee Meetings!!

Garnett J. Sweeney, M.D.
Speaker of the House

Recommendations, Reference Committee No. 1

The committee reviewed the Report of the Speaker of the House and recommends acceptance with a commendation for a job well done.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Report of the Chairman, Board of Trustees

Highlights of the four regular meetings of the Board of Trustees held during the 1963-64 year included delineation of duties of all the committees under the councils, an effort to reduce publication costs of the Journal, the implementation of the orientation course, and action on recommendations in the field of medical licensure, grievances, and third party medicine.

The Executive Committee of the Board of Trustees scheduled six meetings during the associational year. The Executive Committee takes two kinds of actions: (1) makes recommendations to the Board; or (2) acts on behalf of the Board.

You will agree, I am sure, that it would be time consuming to undertake to report all of the actions listed in the 163 pages of minutes covering the Board of Trustees and Executive Committee during the past associational year. The purpose of this report is to cover some of the more important matters. The minutes of these meetings are always available to any member at the Headquarters Office.

I must pay tribute to the members of the Board for their unquestionable loyalty and devotion to the responsibility of their office. The very high percentage of attendance at all meetings conclusively demonstrates the seriousness with which the members view their obligations. It has been a pleasure and an honor to work with such men.

First Meeting—The Board of Trustees held its first and re-organizational meeting Thursday, September 26, at the Phoenix Hotel in Lexington, Doctor Asman serving as temporary chairman.

Doctor Asman recognized the new members of the Board of Trustees and the new Alternate Delegates to the AMA: John Dickinson, M.D., Glasgow, Western Vice-President; Charles G. Bryant, M.D., Louisville, AMA Alternate Delegate; William W. Hall, M.D., Owensboro, AMA Alternate Delegate; and C. C. Rutledge, M.D., Hazard, AMA Alternate Delegate; Rex E. Hayes, M.D., Glasgow, Sixth District Trustee; W. Donald Janney, M.D., Covington, Ninth District Trustee; and Robert E. Pennington, M.D., London, Fifteenth District Trustee.

He then recognized officers and Board members who were returning to serve on the Board the coming year: Delmas M. Clardy, M.D., Hopkinsville, President-Elect; Carlisle Morse, M.D., Louisville, Central Vice-President; Keith P. Smith, M.D., Corbin, Treasurer; J. Thomas Giannini, M.D., Louisville, AMA Delegate; Carl C. Cooper, M.D., Bedford, Eastern Vice-President; Wyatt Norvell, M.D., New Castle, AMA Delegate; Donald Chatham, M.D., Shelbyville, Seventh District Trustee; Douglas E. Scott, M.D., Tenth District Trustee; and Hubert C. Jones, M.D., Berea, Eleventh District Trustee.

Doctor Scott was then elected as chairman for the new Associational year.

Doctor Payne was elected vice-chairman. Doctors Snider and Denham were elected to serve on the Executive Committee.

The Executive Committee, which under the Bylaws serves as the nominating committee with the president-elect acting as chairman, presented its recommendations for council and committee personnel during the coming year. The Board gave these matters full consideration.

The request of the Louisville Chamber of Commerce presented at an earlier meeting, asking that the KSMA change its meeting date either one week before or one week later than originally planned, was considered for final action. It was explained that KSMA was asked to change the date in order that a larger national convention of importance to the community might be brought to Louisville at this time.

A quick investigation was made during the meeting and it was decided that the 1964 Annual Session

of KSMA would be held September 29, 30 and October 1.

Second Meeting—The second meeting of the Board for the 1963-64 associational year was held December 12. KSMA Delegates to the AMA reported on the two resolutions that were introduced by our delegation at the Portland Interim Meeting of the AMA in December. It was explained that while the AMA agreed in principle with both resolutions, that various agencies of the AMA were working on the suggestions covered by the two resolutions.

The report of the Council on Legislative Activities was heard and its recommendation that the Association support the legislative proposal to strengthen the Medical Examiners System was approved.

The Board agreed unanimously to support the request of the University of Louisville for increased appropriation by the 1964 Kentucky Legislature.

The Board voted to resist any legislation designed to change Tuberculosis Hospitals into Chronic Diseases Hospitals.

It was agreed by members of the Board to go along with the State Board of Health in drafting regulations providing for limited licensure for interns and residents on an annual basis.

The Board agreed to make an appropriation in the amount of $7,500 for the coming year to the Kentucky Educational Medical Political Action Committee's Board of Directors for educational purposes, and the Board also appointed directors for KEMPAC for the 1964 calendar year.

Under the recommendations of the Council on Medical Education and Hospitals, the Board voted to have the faculty achievement awards presented each year during the President's Luncheon at the Annual Meeting.

Also, the Board voted on a recommendation of the Council on Medical Education to continue the present appropriation for postgraduate medical education and finally, approval was given for the paying of honoraria to the Senior Day speakers.

Appreciation was officially expressed to Eugene Conner, M.D., the editor of the special Sixtieth Anniversary Issue of The Journal. It was indicated that twenty-three of the twenty-eight Board Room Chairs have been contributed by members.

Third Meeting—The Board of Trustees held its third regular meeting of the year at Jenny Wiley State Park Wednesday, April 22. Following the approval of the President's Report and Headquarters Office Report, the recommendations of the Advisory Committee to the Editor were considered.

These included reducing the number of scientific pages to nineteen, alternating certain departments, deletion of the Washington Page and other suggestions designed to reduce the cost of publishing the Journal.

A recommendation from the Council on Scientific Assembly to increase from $50 to $100 the honoraria paid guest speakers was not accepted.

A resolution expressing appreciation to the President, the Chairman and Co-Chairman of the Council on Legislative Activities, Mitchel B. Denham, M.D., Mr. Bobbie Grogan and all KSMA Key Men at all levels for the excellent work done during the Legislature was unanimously passed.

Eugene Conner, M.D., professor and chairman of the Department of Anesthesiology at the University of Louisville was elected the official historian of KSMA to succeed the late Emmet F. Horine, M.D.

The Board unanimously went on record endorsing the candidacy of Robert C. Long, M.D., Louisville, to succeed himself as a member of the AMA Board of Trustees when the Annual Meeting of the AMA is held in San Francisco in June.

As a matter of properly recognizing the Woman's Auxiliary to KSMA, the Board of Trustees adopted a resolution authorizing the operation of the Auxiliary as an adjunct of the Association.

Consideration was given to Resolution B submitted by the Campbell-Kenton County Medical Society to the 1963 KSMA House of Delegates. The House accepted the reference committee report sending the resolution to the KSMA Board of Trustees for its final disposition. After full discussion, the Board voted to return the resolution to the Campbell-Kenton County Society with the statement that "The Board is in sympathy with the inherent intent of the resolution," but felt it would not be able to specifically implement it.

Following consideration of the grievances, which involved a number of the districts, the Board turned its attention to the reports of the Councils.

The House of Delegates had authorized each of the six KSMA Councils to delineate the duties of the committees under each council and make recommendations to the Board of Trustees.

The Board voted that as these recommendations of the Councils were approved, they would become the policy of the Association covering the broad duties of the committees. General duties of each Council are set forth in the Bylaws.

The Board accepted the recommendation from the Council on Communications and Public Service that KSMA be permitted to endorse commercial advertising under the auspices of the association or county medical society concerning public service programs in medicine such as emergency calls, house call problems, dealing in good taste with factual medical problems. The Mandatory Indoctrination Program, approved by the 1963 House of Delegates, had been referred to this Council for recommendations as to implementation. These were read and approved by the Board.

The Board passed a motion requesting the Committee on Public Health to investigate encroachments by the State Department of Health on the private practice of medicine and report back at the next meeting of the Board. The recommendation was accepted that an organization of physicians interested in the medical aspects of sports be set up.

The following recommendation from the Advisory Committee of U of K, was accepted, among others:

> "The primary function of the University Hospital is education. It is designed for the instruction of students and to facilitate the continuing postgraduate education of the practicing physician as well as the advancement of scientific knowledge through research. Regrettably, the University Hospital, therefore, must differ from a community hospital. Though offering to care for as many patients as it is able, it cannot, in justice to its fundamental objective, accept all patients who present for admission."

The Board approved the budget as presented by Doctor Dixie Snider, Chairman of the Budget Committee. And in that short sentence as in others in this report, there are covered many, many hours of thoughtful work.

The Board voted to ask the State Board of Health to make available to the association more information on new programs it was undertaking, except in emergencies.

The Board adjourned after being in session eight hours and forty-five minutes at 5:45 p.m.

Fourth Meeting—The fourth regular meeting of the Board of Trustees was held Wednesday evening, August 5 and all day Thursday, August 6 in the Board Room at the Headquarters Office.

The President's report covering his varied activities since the April 22 meeting of the Board was complimented by the chairman and unanimously accepted.

Sam A. Overstreet, M.D., and Walter S. Coe, M.D., were unanimously elected for another two-year term as editor and associate editor respectively of The Journal of KSMA.

At this meeting of the Board each year the reports of all councils, and standing committees that are to be submitted to the House of Delegates are reviewed.

Recommendations to the House of Delegates on these reports will be found at the conclusion of each report in the House of Delegates envelopes.

The Board voted to make a one-quarter page ad in the special Courier-Journal supplement, which will be published Sunday, January 17, 1965 commemorating the centennial of the University of Kentucky.

A recommendation of the Executive Committee cited the extremely heavy workload of the three male members of the KSMA Headquarters Staff and after probing various remedies, recommended that a fourth man be added to the Headquarters Staff. After full discussion, the Board voted to implement the Executive Committee recommendation. The Executive Secretary was authorized to re-arrange office space in this connection.

Following the approval by the House of Delegates of *Resolution L* from Muhlenberg County stating that the interest of patients are best served under conditions of free choice of physician and of hospital, and of fee for service, the Board of Trustees appointed a committee to investigate medical practices in those areas of Eastern and Western Kentucky where methods of practice were noticeably in question in these respects. The committee made its report at the August meeting of the Board of Trustees. The report with its recommendations has been referred to the Judicial Council of the AMA for clarification of ethical points in the situations reported and in the implementation of the committee's recommendations. The reply from the Judicial Council is being awaited.

You will recall that a year ago you approved the recommendations of your Board of Trustees to the Appalachian Regional Hospital, Inc. The recommendations were three: that practice in the hospitals be on a fee for service basis; that there be free choice of physician: and that there be no doctor's offices in the hospitals. While it cannot be said that any of these things have been yet fully accomplished, all of them must eventually be, if more doctors such as the area needs are to go there without handicap.

The Board of Trustees appointed a committee to meet with the director of these hospitals to discuss and keep informed on medical practice in the area and in the hospitals. The committee has met on three occasions during the year, twice with Karl Klicka, M.D., President of ARHI, and practitioners in the area. James Holloway, M.D., chairman of our Hospital Committee, and a member of this special committee of the Board of Trustees, has made several trips to the regional hospital area, met with the local hospital advisory councils and physicians in attempting to help with some of the problems involved.

It would have been a sad day for Kentucky if these hospitals would have become empty shells. Their re-establishment has been a magnificent undertaking of the Presbyterian Church and deserves all the support we can properly give it.

The special committee appointed by the Board of Trustees consisted of the President of the Association, the President Elect, the Chairman of the Hospital Committee, and the Chairman of the Board of Trustees. This committee feels strongly the value and importance of the three recommendations made originally by the Board of Trustees. These appear basic to any other advice or help we can give these hospitals.

We are becoming aware of the difficulties in establishing new fundamentals such as these for institutions where they had never existed. The difficulties are complex and present variations in different hospital areas. They cannot be overcome suddenly or at once everywhere. ARHI, however, is to be commended by us on the considerable accomplishments of its first year. And on this we can hope for a future of fine institutions in areas that will be attractive to physicians.

The rate of such further development we believe will be in proportion to the application of our stated recommendations: Freedom of choice of physician; fee for service, and no doctor's offices in these hospitals.

The Chairman of the Board called on the six trustee district grievance committee chairmen to give reports on matters pending in their districts.

Other actions of the Board included approval of a suggestion that an appropriate committee of the KSMA meet with a like committee of the Kentucky State Association of Registered Nurses to plan an agenda for a joint meeting with representatives of the two groups later in the fall; to ask the Office of Dependents Medical Care to print a new fee schedule covering the true medicare program in Kentucky; heard a report on proposed IRS efforts to tax income from advertisements in scientific journals and voted special commendation to Harold McPheeters, M.D., the retiring Commissioner of Mental Health.

In closing this report, the chairman would like to express his appreciation to all the members of the Board and those who have met with the Board for their contributions in expediting the Association's business.

Douglas E. Scott, M.D.
Chairman

Recommendations, Reference Committee No. 1

The committee reviewed the Report of the Chairman of the Board of Trustees, which is a resume, of the actions taken by the Board of Trustees during the year and it also was noted by this committee that the Board of Trustees has been extremely active and has spent many long hours carrying out the actions of this organization.

This committee recommends acceptance of this report with commendation to Doctor Scott and members of the Board of Trustees for their devotion to the responsibilities of their offices.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Report of the Secretary

One year ago the Secretary's Report consisted, in part, of the philosophic reflections of Woody Troutman after seventeen years of devoted and dedicated service to the Association in this office. His words, and his works, have been a source of inspiration to me.

This report will relate some of the impressions gleaned from this, the first year of the three-year term to which you elected me last September. The job of Secretary of the Association is not an arduous one. It does consume a certain amount of time away from one's practice for meetings of the Board of Trustees, the Executive Committee of the Board, the annual and interim meetings, and certain committees and councils.

There are frequent conferences, personal and by telephone, with the Executive Secretary, and occasional decisions to be made to expedite the affairs of the Association if the President and Chairman of the Board are not immediately available. The vast volume of the work, however, and the countless minutiae are handled by our very capable Executive Secretary and his administrative staff.

What, then, are these impressions? I am impressed by the seriousness with which the elected officials of the Association accept the responsibilities of their offices; with the readiness with which these men travel from all parts of the state, at no expense to the Association, for Board meetings to implement the dictates of this House, to establish policies between meetings of the House, and to conduct the ordinary business of the Association. As an example of this devotion to duty, I would mention the almost 100% attendance at a two-day meeting of the Board of Trustees on August 5 and 6, when the Board was in session for twelve and one-half hours.

I admire the accomplishments of our Delegates and Alternate Delegates to the AMA who work so faithfully to represent the members of this Association and the people of Kentucky; and the many mem-

bers of KSMA Councils and Committees who, one might say, do the "grass-roots" work of fulfilling many of the functions and purposes of our Association; and, lastly, this House of Delegates, the legislative body of the Association, for the seriousness and astuteness of its deliberations in setting the policies of our organization.

I am impressed by the tremendous volume of work performed by our Executive Secretary, his Assistants and the personnel of the Headquarters Office. Few of us realize that there are more than sixty Boards, Councils and Committees functioning within the frame-work of the Association. The Executive Secretary and his assistants must "staff" each meeting of each of these groups: working with the chairman in planning the meeting, preparing the agenda, providing background material, keeping the minutes and preparing the permanent digest of the proceedings, implementing the instructions and directions of the committee, and representing the committee at other meetings.

Contemplate for one moment the amount of work and time, the amount of administrative "know-how" that is evident in the organization and smooth working of this annual meeting. In one period of three months the administrative staff worked and/or attended 26 association Council and committee meetings, 22 other meetings of association groups and various health-related organizations, and three out-of-state meetings on the national level.

Bear in mind that these councils and committees have been created by us, the association and cooperation with other health-related groups have been dictated by this House, by the Board of Trustees, or by the facts of life in the 1960's, and the Administrative staff is doing *our* work in fulfilling the purposes for which KSMA was organized and which justifies its continued existence.

Turning over the coin, I have been impressed in a negative sort of way by a relatively few members of the Association, including some members of this House, who consistently criticize the officials of the Association, condemn its activities, and complain about its dues. This attitude would appear to be due either to a failure of communication between the officials and the members, or to apathy on the part of the member. The latter explanation is favored since every member has the opportunity to learn and understand the workings of his Association—if he is willing to take the time and make the effort.

All meetings of this House, of the Board of Trustees, and of all Councils and Committees are open to every member in good standing. The Journal, the Communicator and other publications of the Association are mailed to every member. There is every opportunity to be informed on—and to be active in—the affairs of the Association.

As your Secretary, I believe you are being conscientiously represented, your money is being well spent, and your Association is a worthy "face" of organized medicine in Kentucky in 1964.

Henry B. Asman, M.D.
Secretary

Recommendations, Reference Committee No. 1

The committee reviewed the Report of the Secretary to the House of Delegates with its remarks and recommends acceptance of this report with commendation to Doctor Asman for a job well done.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Report of the Editor

The past year has been marked by no unusual changes in the Journal. Continuity of policy and detail has been effected by weekly meetings of the managing editor, J. P. Sanford, with the Editors and by fairly frequent contact with the chairman of the Advisory Committee to the Editor, George Brockman, M.D. The Council commissioned the advisory committee to make a study of the financial affairs of the Journal. This was done in a very efficient manner by Doctor Brockman and his committee in a meeting held at Headquarters on January 16, 1964. The policies suggested at that time have been implemented so far as is practical.

There have been twelve monthly Editions of the Journal. On October of 1963 Beverly Towery, M.D., did the symposium issue featuring Endocrinology. In November of 1963 Eugene Conner, M.D., edited the 60th anniversary issue which apparently was well received by the subscribers. In January of 1964 William Rumage, M.D., edited the Disaster Care Issue presenting before the readers many neglected features of disaster care which have been promoted by the American Medical Association.

Curtailment of scientific matter in the Journal has been necessary because of the limited revenues from advertising. It is well known that there has been a significant decrease in drug advertising in general. During the past three years the Kentucky Medical Journal has perhaps felt the impact less severely than have other state journals of our class. It has, however, been necessary to delete certain monthly features and publish others on a three-month-basis in order to keep a satisfactory balance between scientific and advertising matter. Mr. Sanford believes that there are prospects for substantial improvement in this respect during the present year and next.

It should be pointed out that no subscription fee for the Journal is taken from the Kentucky State Membership dues each year. If a subscription fee of $5.00 or $10.00 every year were channeled into the Journal as is done in some states, we would be able to present a better financial picture than we are able to under the present plan. We and the Editors' Advisory Committee do not particularly recommend that any such change be effected; it would be only taking money out of one pocket and putting it into the other. We merely wish to point to this as the principal explanation of the Journal's financial deficit.

At the July meeting of the Board of Trustees Doctor Coe and I were reelected to our respective offices for a term of two years. We wish to express our gratitude to the trustees for this expression of confidence which we shall endeavor to justify.

Sam A. Overstreet, M.D.
Editor

Recommendations, Reference Committee No. 1

The committee reviewed the Report of the Editor of the Journal of KSMA and wish to commend Doctor Overstreet for a job well done in maintaining the excellence of our Journal under difficult circumstances and recommends acceptance of this report.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried.)

Report of the Treasurer* **

Recommendations, Reference Committee No. 1

The committee reviewed the Report of the Treasurer, which is a well prepared report of our financial status and wish to commend Doctor Smith. We recommend acceptance of this report.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

**(Note: Any member wishing to see a copy of the Treasurer's Report may do so by writing the KMA Headquarters Office, 3532 Janet Avenue, Louisville, Kentucky 40205.)*

***Please see Organization Section, page 1018, for graph showing distribution of KMA funds.*

Report of the Delegates to the American Medical Association

Your Delegates had a successful year as your KSMA representatives to the AMA House of Delegates. The Clinical Session of the AMA met in Portland, Oregon, December 1 to 4, 1963 and the 113th Annual Session met in San Francisco, California, June 21 to 25, 1964.

The clinical session at Portland was to have been the last meeting in which J. Vernon Pace, M.D., Paducah would have served as a delegate from KSMA. However, Doctor Pace decided to "step-aside" and allow John Quertermous, M.D., Murray, Kentucky, the AMA Alternate Delegate from the Western section of Kentucky, to be seated as delegate rather than serving as alternate at the Portland meeting. Doctor Pace should be praised for this by the entire KSMA and your senior delegate from Kentucky called the attention of the AMA House of Delegates to this unselfishness of Doctor Pace.

Tobacco and health, human rights, physician-hospital relations, continuing medical education, the cost of medical care and federal subsidization of prepayment plans and health insurance companies were among the major subjects acted upon by the AMA House of Delegates at both the Portland and San Francisco meetings.

The House of Delegates recommended that the AMA Board of Trustees use the talents of Edward R. Annis, M.D. and other qualified spokesmen for medicine with appropriate remuneration.

Norman A. Welch, M.D., Boston, Mass., was inaugurated as AMA President, Donovan F. Ward, M.D., Dubuque, Iowa was named President-Elect of the AMA. Carlton Wertz, M.D., Buffalo, New York, was named Vice President. Milford Rouse, M.D. of Dallas and Walter C. Bornemeier, M.D. of Chicago was named Speaker and Vice-Speaker of the House respectively.

There were two members of the Board of Trustees of the AMA standing for re-election—R. R. Robins, M.D. of Camden, Arkansas, and our own Robert C. Long, M.D. of Louisville, Kentucky. Alvin J. Ingram, M.D. of Memphis, Tennessee opposed Doctor Robbins and was elected in a very close vote. Doctor Long had no opposition and was re-elected for a three-year term to the Board of Trustees. The extreme high level of respect for Doctor Long is attested to by the absence of any opposition to his membership on the Board of Trustees. Doctor Long was also appointed to membership on the AMA-ERF Board of Directors.

The speaker of our own House of Delegates, Garnett J. Sweeney, M.D. of Liberty, suggested to the Board of Trustees of KSMA that the delegates and alternate delegates to the AMA be in attendance at the Reference Committee meetings. The delegation will serve as reference sources for the reference committee deliberations. Your delegates and their alternates will attend the same reference committees it was their responsibility to attend at the AMA sessions.

George P. Archer, M.D., our KSMA President has repeatedly recommended and urged the component medical societies of KSMA to use their delegation to the AMA House of Delegates for programs. Especially as sources of information as to AMA attitudes, positions, decisions, etc., which at times is misunderstood misconstrued, misinterpreted because of lack of communication.

Your delegation is available to fulfill your invitations.

Your AMA Delegation would be remiss if they did not express their appreciation for the help given them by Deans Smith and Willard, Doctors M. R. Cronen, David Cox, Carl Cooper, George Brockman, Murray Kinsman and many other Kentucky physicians. To our wives, our appreciation and thanks for a job well done in the Kentucky Hospitality Room. And last, but definitely not the least in important work, our Executive Secretary Joe Sanford and his assistant, Bob Cox, our thanks.

Wyatt Norvell, M.D.
Senior Delegate to the AMA

Recommendations, Reference Committee No. 1

The committee reviewed the Report of the Delegates to the AMA which is a resumé of their activities during the year, and especially, at the AMA convention. We wish to commend all of our delegates and alternate delegates, and especially, to commend Doctor Robert C. Long for his excellent representation of the KSMA and we recommend acceptance of this report.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Report of the Executive Secretary

If you were to count all of the committees, councils, the House of Delegates on the KSMA organizational chart and add a few ad hoc committees that have been named for special tasks, you would see that there are more than 65 different groups operating within the KSMA during this Associational year. In one way or another, the work of each of these groups —together with the officers of the Association—will be manifested in the reports to this House or in the functioning of this House. In the background you will find your staff carrying out your directions.

Consider for a moment the magnitude of effort involved by all of the committees, councils, and different KSMA groups in determining the contents of your envelope. Beginning in May meetings are scheduled—having sometimes as many as two and three in one day—as the various groups put together their reports. Sometimes, there are problems in arranging meetings, fighting vacation schedules and lack of understanding of the problem. After this is determined, the Headquarters Office has the responsibility of assembling this material, meeting the deadlines, cutting the stencils, proofing, and assembling the 250 copies of each report. This adds up to a total of nearly 225 pages in your envelope.

The work of the committees, Councils, Board of Trustees, and officers as reported in your envelope involves a substantial portion of the time and effort of your staff during the year. It is the responsibility of the staff to arrange for meetings, work with the chairmen on preparing the agenda and arranging background material, attend the meetings, write the digest of proceedings, implement policies, write a digest of the committee's meeting for the Journal, and assist in the preparation of these reports.

On the basis of a 40-hour week, I spend 4½ weeks attending 44 KSMA committee meetings, other medical and related meetings numbering 53 for a total of 97 meetings. Mr. Cox worked 55 KSMA committee meetings for a total of 182 hours. The staff as a whole spent 706 hours (17 weeks) attending 243 KSMA sponsored or related meetings. In a limited number of instances, it was necessary for more than one staff member to be present.

Let's consider what goes into staffing the meetings of the Board of Trustees. This twenty-eight member Board met six times during the past Associational year and was in session slightly more than 35 hours. The Executive Committee of the Board also held six sessions spending approximately 18 hours. A considerable amount of time was spent by the staff in preparing and distributing material to each member of the Board in order to assist the Board in carrying out your work with greater efficiency in the minimum amount of time. Minutes of these meetings cover more than twenty-five pages.

Another year-round activity of the staff is the preparation for this Annual Meeting. You might be

interested in the procedure of working with the 14 specialty groups—the general scientific sessions. Because of the time limit, let's consider only one—that of preparing for the technical exhibits display.

The technical exhibits hall provides the member with a vast wealth of information, adds color to the meeting, and makes it possible for us to have one of the best small state meetings in the country without cost to you. In the preparation for this exhibit, we will write more than 300 letters to the 75 exhibitors which will contribute this year nearly 10% of our total income.

As your committees and councils seek to serve the public and the profession, new programs involving a greater amount of staff time are developed. A case in point is the recently re-activated Mental Health Committee-sponsored First Conference on Mental Health in May. Many staff hours were involved in promoting the Congress, working with allied and other organizations, meeting arrangements, numerous mailings to individuals and groups, working with the chairman and members of the committee, and making arrangments for speakers.

One of the most important activities of the Headquarters Office concerns working in the legislative area both state and national. In this field the necessity for quick and sometimes extended activities often comes in the midst of other highly important staff responsibilitiies which frustrates the orderly accomplishment of business. This year, the legislators met in Frankfort and our Director of Field Services was on the scene both day and night practically every day the legislature met.

As emergencies arise in Washington, your staff must be equipped and in a position to momentarily dispense information through the KSMA Key Man System in order that you may be appropriately informed to make such decisions and take such actions as are necessary.

Another KSMA public service program which is rendering an increasingly important service to the public is the Placement Service and Rural Kentucky Medical Scholarship Fund. We are now averaging about one call a day by the placement service. This time-consuming program includes helping both representatives of communities wanting physicians and physicians wanting other physicians to assist them and physicians looking for places to locate.

The carrying on of the house-keeping activities of the Scholarship Fund is an absorbing task for the Director of Field Services and involves almost 50% of the time of his secretary.

Another note-worthy accomplishment during the year involving considerable staff time was the implementing of the 1963 House of Delegates action calling for the delineation of the duties of all KSMA committees. Following approval of the recommendations to the Board of Trustees, this information has been compiled in a 15-page report. From now on, when a committee is appointed each member will receive a copy of the statement of the duties of the committee. This information will also be available to officers and other members who may wish to have it.

It is not feasible to undertake the reporting of all staff activities. Perhaps your attention should be called to the major programs, however, that involve a great amount of time. These include the Interim Meeting, the Rural Health Conference, the great amount of follow-through involved in the work of the Highway Safety Committee and the Disaster Medical Care Committee with State Governmental Agencies, and the Diabetes Education and Detection Drive (which is one of our most popular public service programs).

Coordinating the material that goes into the Journal of KSMA ordinarily means the collection and preparation for publicition of the scientific material in the Journal which is a considerable task in itself. The KSMA Communicator is prepared by the staff under the direction of our secretary and numerous news releases covering the KSMA programs are distributed throughout the year.

As the services of the Association to the profession and public increase, so does the number of telephone calls. I will average from 12 to 20 incoming calls a day and from 10 to 15 outgoing calls. Other members of the Executive staff run about the same. During legislative emergencies, the phone-call load may double or triple.

We hope in highlighting a few of the activities of our staff here will give you some indication of the volume of work that is carried on each year in your behalf. You are more than welcome to visit our Headquarters and personally inspect your Association's operation.

All of the members of the Headquarters staff join me in expressing our full appreciation for the kindness, consideration, and cooperation shown us and the fine direction given to us during the Associational year by the President, the Chairman of the Board, the Speaker of the house, the Secretary and the Treasurer, the Editor of the Journal and all of the Council and Committee Chairmen and members.

To the other members of the Headquarters Staff, I want to express my unlimited gratitude for the dedication and efficiency you have demonstrated in taking care of the largest volume of work that the staff has yet been asked to handle in any one year. It is a pleasure to work with all of you, and I'm most thankful for your loyalty to KSMA.

J. P. Sanford
Executive Secretary

Recommendations, Reference Committee No. 1

The Report of the Executive Secretary was reviewed which is a resume of the services performed by Mr. Sanford and his Headquarters Staff. We wish to take this opportunity to thank and commend Mr. Sanford and his entire Headquarters Staff for their usual excellence in performance of their duties.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried.)

Report of the McDowell Home Committee (Paragraph 3, page 4)

It is a matter of pride that the Association should continue to maintain this National and World Shrine in a proper manner. The financial contribution of the Kentucky State Medical Association is obviously necessary, and it is logical to increase this contribution from $3,000 to $4,000 per annum.

The following is the financial report as prepared by the financial office of the Kentucky State Medical Association.

STATEMENT OF INCOME AND EXPENSE— McDOWELL FUND FISCAL YEAR, JULY 1, 1963—JUNE 30, 1964

	ACTUAL	BUDGET	
		Budget Allowance	Over or (under) Actual
McDowell Home:			
Income:			
Kentucky State Medical Association Appropriation	$3,000.00	$3,000.00	$ —
Kentucky Surgical Society Contribution	1,000.00	1,000.00	—
Admissions, Sale of Cards and Books	1,399.11	1,000.00	(399.11)
Miscelloneous Donations	655.00	750.00	95.00
Total Income	6,054.11	5,750.00	(304.11)

Expenses:			
Repairs to Home	1,919.19	500.00	(1,419.19)
Salary - Hostess	1,429.00	1,380.00	(49.00)
Insurance	525.69	500.00	(25.69)
Supplies	113.77	200.00	86.23
Telephone	203.23	200.00	(3.23)
Publicity	707.36	300.00	(407.36)
Payroll Taxes	82.60	80.00	(2.60)
Gas and Electricity	631.96	500.00	(131.96)
Miscellaneous Services, etc.	1,166.53	800.00	(366.53)
Sales Tax	40.40	50.00	9.60
Total Expenses	6,819.73	4,510.00	(2,309.73)
Excess Expense Over Income	$ (765.62)	1,240.00	$(2,005.62)
ACTUAL UNDER BUDGET		(2,005.62)	
		$ (765.62)	

Recommendations, Reference Committee No. 1

This committee reviewed paragraph 3, page 4 of the Report of the McDowell Home Committee which deals with the necessity to increase the financial contribution of the KSMA to the McDowell Home Fund from $3000 to $4000 per annum. This committee, in reviewing its treasurer's report, notes this increase is necessary for the continued operation of this National and World Shrine in a proper manner, and recommends acceptance and implementation of this recommendation.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Resolution E

Campbell-Kenton County Medical Society

WHEREAS, we are all deeply impressed by the ability of Dr. E. Annis, M.D., to stand before any type of audience and present the case for "American" Medicine as we know and desire it and

WHEREAS, we feel that his services are so valuable that his ability should be used by the American Medical Association permanently in the fight against socialized medicine and

WHEREAS, it is our opinion that he has brought more favorable publicity for the American Medical Association and the American Doctor than any other single representative of American medicine, therefore be it

RESOLVED,

That Dr. E. Annis, M.D., be urged to accept lifetime employment by the American Medical Association as Representative of American Medicine to the people of the United States, at a salary commensurate with his earning capacity in private practice.

Recommendations, Reference Committee No. 1

Resolution E introduced by the Campbell-Kenton County Medical Society, which recommends that Doctor E. Annis, M.D., be urged to accept lifetime employment by the American Medical Association as Representative of American Medicine to the people of the United States, at a salary commensurate with his earning capacity in private practice was reviewed by this committee and we recommend acceptance of this resolution.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried.)

Mr. Speaker, I move the adoption of the report of Reference Committee No. 1 as a whole. (Motion was seconded and carried.)

REFERENCE COMMITTEE NO. 1
Ballard W. Cassady, M.D., Pikeville, Chairman
T. R. Bryant, Jr., M.D., Lexington
Walter L. Cawood, M.D., Ashland
Mary Pauline Fox, M.D., Hazard
Robert T. Longshore, M.D., Covington
Paul J. Ross, M.D., Louisville

REFERENCE COMMITTEE NO. 2 †

W. Gerald Edds, M.D., Chairman

Reports on Scientific Assembly and Medical Education

† *See note (†) bottom of column one, page 962.*

Reference Committee No. 2 considered the following reports:

11. Report of the Council on Scientific Assembly

12. Report of the Council on Medical Education and Hospitals

Resolution C — Straight Internships vs. Rotating Internships

Resolution D—Private Hospital Internships

1. Report of the President

Report of the Council on Scientific Assembly

PREFACE

Procedures for reports of councils and standing committees of KSMA to the House of Delegates are provided for under Chapter VII, Section 4 of the By-laws, which reads in part:

". . . Each standing committee and council shall report annually at least six weeks prior to the Annual Meeting, to the House of Delegates via the Board of Trustees, respecting its activities during the year last past. These reports shall be transmitted without alterations or amendment to the House of Delegates by the Board of Trustees at the Annual Meeting, with such comments or recommendations as the Board cares to make . . ."

The material is this report of the Council on Scientific Assembly is presented in the following order:

1. *Actions and recommendations by the Council which it undertook on its own initiative.*
2. *Reports of the committees of this Council with the Council recommendations following each committee report.*
3. *Recommendations by the KSMA Board of Trustees on the overall contents at the conclusion of the report.*

* * * *

Results of the 1963 KSMA Annual Meeting were carefully reviewed by the Council when it held its meeting on October 16. Members of the Council felt that the 1963 meeting held in Lexington went very well indeed in view of the physicial and other limitations that figured prominently in its development. It was reported that the specialty group scientific programs were quite well attended.

The Council then turned its attention to the 1964 Annual Meeting. Inasmuch as this annual session was to be held in the new Convention Center, It was necessary for the council members to do an on-the-spot inspection and organize the facilities in what it hopes will serve the best interest of all concerned.

The Council was pleased to learn that the Smith Kline and French people would again sponsor a Trans-Atlantic CPC. It was decided that again Wednesday afternoon would be set aside for as many specialty groups as possible to meet, and with other specialty groups holding their meetings simultaneously

where there is no conflict in subject matter. The cooperation of our fifteen specialty groups is greatly appreciated.

Since the past two meetings had experimented with the "symposuim in depth" approach to scientific programming, it was decided to relax this policy somewhat, and permit more individual presentations.

Your Council members feel perhaps that the average KSMA member is not aware of the tremendous amount of committee work involved in the planning, development and presentation of an annual meeting the size of our meeting. Your Council would point out that because our Committees take their obligations so seriously and plan so effectively, we have one of the best small state meetings in the nation. The members of our Council wish to express their deepest appreciation to all who have contributed to the success of this meeting.

The following reports of the committees serving under the Council are herewith submitted.

Recommendations, Reference Committee No. 2

Reference Committee No. 2 met and considered the report of the Council on Scientific Assembly. Your Reference Committee is well pleased with the efforts of the Council and wishes to commend it and also the committees under the Council on the excellent work that it has done.

Scientific Exhibits Committee, Benjamin B. Jackson, M.D., Louisville, Chairman

The KSMA Scientific Exhibits Committee met on July 15 to review applications and select exhibitors for the 1964 KSMA Annual Meeting.

The Committee is appreciative of the continuing interest in Scientific Exhibits. Eighteen exhibits were approved for the meeting. All exhibits are to be in place by 8:00 a.m., Tuesday, September 29 and are not to be removed until 3:30 p.m., Thursday, October 1.

A special committee will judge the exhibits on Tuesday morning and select the first, second and third place winners. A plaque will be presented to the first place winner during the Scientific Session, Wednesday morning, September 30. A certificate of appreciation signed by the KSMA President and Chairman of the Board of Trustees, will be given to each exhibitor as in the past.

Recommendations, Reference Committee No. 2

The Scientific Exhibits Committee report was reviewed and it was noted that there are 18 carefully selected exhibits. Your Reference Committee feels that this committee should be applauded.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried.)

Scientific Program Committee—Douglas M. Haynes, M.D., Louisville, Chairman.

Your committee held two meetings during the year and your chairman attended several other meetings with different groups while putting together the plans for the 1964 KSMA Annual Meeting Scientific Program.

Members of your committee met with representatives of the fifteen cooperating specialty groups to make plans and coordinate their participation in the scientific programming for this session. This committee wishes to express its appreciation to all the cooperating specialty groups for the splendid contribution they make to our overall scientific program.

As pointed out in the report of the Council, policy for the format of the general session scientific programs was changed this year, permitting more individual presentations. Your committee, however, is pleased to report that guest speakers were cooperative in following the committee's wishes in the scientific areas the committee wished covered.

Much preparatory effort has gone into the plans for the Trans-Atlantic telephone conference that will be presented Tuesday afternoon at 2:00 p.m. This should be a most worthwhile and practical presentation.

Our committee was asked to consider and is glad to approve the suggestion that the period of 7:00 a.m. to 8:30 a.m. be set aside Wednesday morning for meetings of the various medical-religious group programs. We understand the KSMA Committee on Medicine and Religion is coordinating this matter.

The deep and most sincere gratitude of the members of our committee is extended to all of our guest speakers, the specialty group presidents, the hardworking participants in the Trans-Atlantic Telephone Conference and its sponsor, the Smith Kline and French Laboratories, and to all who are participating in the two symposia on Thursday.

Recommendations, Reference Committee No. 2

Your Reference Committee reviewed the report of the Scientific Program Committee and wishes to commend Doctor Douglas Haynes and the members of his committee for the great amount of work and the way it is put together. We would also like to thank the Smith, Kline and French Laboratories for sponsoring the Trans-Atlantic Conference.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded and carried.)

Technical Exhibits Committee, Clyde T. Moore, M.D., Louisville, Chairman

Your committee on technical exhibits is experimenting with two innovations for our 1964 Annual Meeting. The first is a message center that is located at the center of the hall and is designed to be of maximum service to the members in receiving their messages. The center will be presented and staffed by the Southern Bell Telephone Company.

A second experiment relates to the use of the so-called "three-sided booth". Purpose of the "three-sided booth" is to offer more privacy to the member as he seeks information on questions of interest to him and to the exhibitor as he makes his presentation. This is the first experiment of this sort in a medical convention. You are urged to go into each of these booths in order that you may see how it operates and give your reaction to either those who operate the booth, or to our KSMA Headquarters Staff.

This year we have reached an all-time high in space sales for a total of 75, the revenue from which will just about cover the increased cost to the Association of holding the Annual Meeting at the newly renovated, air-conditioned facilities of the Convention Center.

Your committee feels the technical exhibit hall makes many fine contributions to our meeting. To those of you who are officers and delegates—we urge you to visit the exhibits for the information you require and also to express appreciation for the exhibitor's patronage of our meeting.

Recommendations, Reference Committee No. 2

The report of the Technical Exhibits Committee pointed out that we had the largest number of Technical Exhibits in our history. The Committee is fully aware of the amount of work involved in this program and understands that we had the largest number of booths in the history of our Association.

Mr. Speaker, Reference Committee No. 2 recommends the adoption of this report with our appreciation. (Motion was seconded and carried.)

Golf Committee, Kenton D. Leatherman, M.D., Louisville, Chairman

The Golf Committee met on May 28 and finalized the plans for the 1964 KSMGA Golf Tournament which will be held Monday, September 28 at the Big Springs Country Club in Louisville.

In past years the Golf Tournament has been held

over a four-day period during the KSMA Annual Meeting. This created a number of problems including conflicts with the Scientific Sessions. This committee recommended last year that one day be set aside for the Golf Tournament and other recreational purposes at which time there would be no conflict with the Scientific Sessions. This recommendation was approved by the 1963 House of Delegates and the Council on Scientific Assembly has set aside Monday, September 28 as the day for the 1964 Tournament. All participants in the Tournament must play on that day.

Since the Big Springs Country Club will be closed to everyone except the doctors on that day, it is imperative that all participants be pre-registered so that proper arrangements can be made for food, etc. In order to participate in the 1964 Tournament, the Golf Committee will accept only those applications received by September 1, 1964. Publicity and other aspects of the Tournament will be the same as in the past.

COUNCIL ON SCIENTIFIC ASSEMBLY
Harvey Chenault, M.D., Lexington
Douglas M. Haynes, M.D., Louisville
Benjamin B. Jackson, M.D., Louisville
Clyde T. Moore, M.D., Fern Creek
Edmund D. Pellegrino, M.D., Lexington
Delmas M. Clardy, M.D., Hopkinsville, Vice Chairman
George P. Archer, M.D., Prestonsburg, Chairman

Recommendations, Reference Committee No. 2

It was with satisfaction that the Reference Committee noted that the Golf Committee's Tournament was held in one day and was not in competition with the Scientific Session. Your Reference Committee recommends that this practice be continued.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded and carried.)

Reports of the Council on Medical Education and Hospitals

PREFACE

Procedures for reports of councils and standing committees of KSMA to the House of Delegates are provided for under Chapter VII, Section 4 of the Bylaws, which reads in part:

". . . . . Each standing committee and council shall report annually, at least six weeks prior to the Annual Meeting, to the House of Delegates via the Board of Trustees, respecting its activities during the year last past. These reports shall be transmitted without alteration or amendment to the House of Delegates by the Board of Trustees at the Annual Meeting, with such comments or recommendations as the Board cares to make . . . . ."

The material in this report of the Council on Medical Education and Hospitals is presented in the following order:

1. *Actions and recommendations by the Council which it undertook on its own initiative.*
2. *Reports of the committees of this Council with the Council recommendations following each committee report.*
3. *Recommendations by the KSMA Board of Trustees on the overall contents at the conclusion of the report.*

* * * * *

The Council on Medical Education and Hospitals has met three times during the associational year, November 14, 1963, February 20 and June 4, 1964. At its first meeting the Council discussed the activities of its various committees and approved a statement outlining the duties of each committee. The Committees serving under the Council are: Advisory Committee to the University of Kentucky, Advisory Committee to the University of Louisville, AMA-ERF Committee, General Practice Committee and Hospital Committee.

During this past year, the operation of the postgraduate medical education fund was turned over to the Council. We have continued our activities in the field of postgraduate education by maintaining a calendar of all scheduled meetings and serving as a clearing house, and maintaining the publication of the "Continuing Educational Opportunities" page in the KSMA Journal.

At its second meeting, the Council discussed a number of the programs being conducted by the committees serving under the council. Procedures for selecting the 1964 recipients of the KSMA Scientific Achievement Award were outlined and these recipients (one from each of Kentucky's two medical schools) were selected at the Council's third meeting. This Council has been asked to make a study on "Town and Gown" relationships and we developed a questionnaire on Medical Education which we feel will prove useful in studying and improving "Town and Gown" relations. This questionnaire was sent to all Kentucky physicians during June. It is not anticipated that the results of the questionnaire will be tabulated and evaluated in sufficient time to present a report during the 1964 KSMA Annual Meeting.

The members of the Council on Medical Education and Hospitals, believing it would be an added service to the physicians of our state, recommend to the KSMA Board of Trustees that the Board encourage the State Board of Health to include the speciality of each individual physician in future printings of the Kentucky Medical Directory.

The report of the committees covering their activities and recommendations follows:

Advisory Committee to the University of Kentucky, Andrew M. Moore, M.D., Lexington, Chairman

The Advisory Committee to the University of Kentucky met separately and in a joint session with the Advisory Committee to the University of Louisville on February 6, 1964. The committee members reviewed the 1963 report to the House of Delegates of the Council on Medical Education and Hospitals, and made further recommendations as appropriate to this committee.

As a means of making the purposes of the university hospital known and understood by both physicians and the public, the committee approved a statement concerning the university hospital. This statement was also approved by the Advisory Committee to the University of Louisville, the Council on Medical Education and Hospitals, the Board of Trustees, and disseminated to all Kentucky Physicians.

The KSMA Executive Committee requested the Advisory Committee to the University of Kentucky to make a recommendation pertaining to dues for full-time faculty and teaching members. The following recommendation was made in a joint meeting with the Advisory Committee to the University of Louisville.

It is recommended that this motion be submitted to the Constitution and Bylaws Committee through the Board of Trustees with the action taken by the Board of Trustees for action by the 1964 House of Delegates. "The KSMA Advisory Committees to the University of Louisville School of Medicine and the University of Kentucky Medical Center, having studied the dues problem as referred to them by the Executive Committee at its October 31 meeting, recommend that the dues for full-time teaching and research members be fifty percent of the dues for regular active members."

COUNCIL ACTION: The Council on Medical Education and Hospitals accepts the report of

the Advisory Committee to the University of Kentucky. It is noted by the Council that the Board of Trustees, at their April 22 meeting, did not adopt the recommendations of this Committee pertaining to dues.

Recommendations, Reference Committee No. 2

Reference Committee No. 2 approved the report of the Advisory Committee of the University of Kentucky.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Advisory Committee to the University of Louisville, George A. Sehlinger, M.D., Louisville, Chairman

The Advisory Committee to the University of Louisville met once during this associational year on February 6, 1964, and also held a joint meeting with the Advisory Committee to the University of Kentucky on the same day.

At the request of the KSMA Board of Trustees, the committee prepared a statement of the committee's duties, which subsequently was approved by the Council on Medical Education and Hospitals and the Board of Trustees. A number of recommendations made by the Council last year were reviewed and the committee felt the recommendations were being implemented and no further action was taken.

In the joint meeting with the Advisory Committee to the University of Kentucky, a statement concerning the university hospital was approved. This same statement was later approved by the Council on Medical Education and Hospitals and the Board of Trustees, and has been disseminated to the physicians in Kentucky.

The KSMA Executive Committee requested the Advisory Committee to the University of Louisville to make a recommendation pertaining to dues for full-time faculty and teaching members. The following recommendation was made in a joint meeting with the Advisory Committee to the University of Kentucky.

It is recommended that this motion be submitted to the Constitution and Bylaws Committee through the Board of Trustees with the action taken by the Board of Trustees for action by the 1964 House of Delegates. "The KSMA Advisory Committee to the University of Louisville School of Medicine and the University of Kentucky Medical Center, having studied the dues problem as referred to them by the Executive Committee at its October 31 meeting, recommend that the dues for full-time teaching and research members be fifty percent of the dues for regular active members."

COUNCIL ACTION: The Council on Medical Education and Hospitals accepts the report of the Advisory Committee to the University of Louisville. It is noted by the Council that the Board of Trustees, at their April 22 meeting, did not adopt the recommendations of this Committee pertaining to dues.

Recommendations, Reference Committee No. 2

The Reference Committee considered the Report of the Advisory Committee to the University of Louisville by Doctor Sehlinger and approved this report and concurs with the action of the Board of Trustees that the dues of both the members of the faculties of the University of Louisville and the University of Kentucky should be the same as physicians in private practice.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried.)

AMA-ERF Committee, Walter I. Hume, Jr., M.D., Louisville, Chairman

The AMA-ERF Committee did not have a meeting this year. The programs of the American Medical Association Education and Research Foundation have been promoted periodically throughout the year by means of the KSMA Journal and the Communicator. The Committee also had an exhibit at the 1963 KSMA Annual Meeting, and the physicians of Kentucky received additional promotional material on a quarterly basis from the AMA.

Allocations of the 1963 AMA-ERF contributions to Kentucky's two medical schools were presented by check at the 1964 KSMA Interim Meeting to the Deans of the medical schools. The University of Kentucky Medical Center received $5,279.28 and the University of Louisville School of Medicine received $10,369.36. In addition to funds for medical schools, another major project of AMA-ERF is the loan program for medical students, interns and residents. This program made 142 loans to Kentuckians during 1963, compared to 99 loans made during 1962, for a total of $282,100.

The Committee is pleased to have this opportunity to express their appreciation to the physicians of Kentucky and the Woman's Auxiliary for their support of the AMA-ERF.

Recommendations, Reference Committee No. 2

The Reference Committee considered the report of the AMA-ERF Committee by Walter I. Hume, M.D. and noted with pride the contributions to the University of Kentucky Medical Center of $5279.28 and to the University of Louisville School of Medicine in the amount of $10,369.36.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

General Practice Committee, Homer B. Martin, M.D., Louisville, Chairman

Since the work of the entire year was reviewed at the May 7, 1964, meeting of the Committee held in Louisville, our report will cover this one meeting. Interest in general practice affairs by each individual was shown by the perfect attendance. A representative of each medical school kindly attended and contributed to the meeting discussions.

1. Resolution M—Actions by Our Medical Schools.

Resolution M was submitted to the House of Delegates last year by the Laurel County delegates. In essence, this resolution called the attention of our medical schools to the attrition in the numbers of general practitioners and asked what specific actions were being planned to offset and reverse this trend. This committee was assigned this resolution.

Dr. Charles F. Blankenship, Chairman of the Department of Community Medicine, University of Louisville School of Medicine, stated that the general practice lectures were considered worthwhile and would be continued. A more desirable time is being sought so that all students can benefit from them. He expressed the interest of the school in programs being developed at the University of Kentucky and elsewhere.

Dr. Nicholas J. Pisacano, Director of Postgraduate Education at the University of Kentucky College of Medicine, then discussed the exploratory efforts of the school to formulate a three-year program which would provide adequate training in family practice. To this end, a meeting was held in Lexington during March of this year which brought together the nation's leading authorities in this field. Despite the enthusiasm of the Kentucky faculty, progress must be deliberate and the present goal is tangible progress rather than publicity about the program which is still in the planning stage. After Dr. Pisacano's discussion, members of the General Practice Committee made specific suggestions and criticisms of the course of study being organized.

Dr. Seeley then moved that the committee report to the Board of Trustees that both state schools are evincing satisfactory progress in formulating programs as sought by Resolution M and we recommend the House of Delegates express their willingness to each school to assist these proposed and current programs in any way possible while stressing the

urgency and desirability of such programs. The motion was passed unanimously.

II. Questionnaire Comparing General Practice and Specialty Practice.

To gain understanding of the reasons why diminishing numbers of medical graduates enter general practice with a proportionate increase in specialty ranks, the committee early this year prepared a mail questionnaire. This was to be sent to each Kentucky physician who was known to have done both general and specialty practice. Eighty forms were sent out and 52 replies were received.

The physicians responding represented 16 different specialties. They had started their specialty practice at an average age of 35. Their average age is now 46. Their replies were based on a collective total of 267 years in general practice. In the decision to enter specialty practice, these factors were rated in importance as follows:

Table 1: Factors in Decision to Specialize

	Per Cent Rating the Importance As		
	Major	Some	None
Personal Satisfaction from Work	48	23	29
Feelings of Inadequacy	44	34	22
Family Time	40	42	8
Formal Postgraduate Time	41	38	21
Recreation Time	19	58	23
Time to Study at Home	28	48	24
The Work Load	24	50	26
Lack of Intellectual Challenge	27	34	39
Inadequate Cultural Facilities	34	20	46
Inadequate Physician Contact	26	35	39
Income Received	0	43	57
Status as General Practitioner	12	30	54
Lack of Hospital Privileges	16	23	61
Personal Health Factors	9	26	65

As to how these items were affected by specialty practice, a comparison is offered below. It is striking that *none* of the factors is considered worse in specialty practice.

Table 2: Changes Effected by Specialty Practice

	Per Cent Rating Factors		
	Improved	Unchanged	Worse
Feelings of Adequacy	69	31	0
Time for Postgraduate Courses	76	22	2
Time to Study at Home	67	31	2
Contact with Fellow Physicians	66	32	2
Cultural Facilities	65	33	2
Intellectual Challenge of Practice	76	20	4
Personal Satisfaction from Work	74	20	6
Family Time	69	25	6
Recreation Time	62	32	6
Status	54	40	6
Work Load	56	34	10
Income	55	31	14
Hospital Privileges	45	51	4
Personal Health Factors	27	67	6

As to whether general practice was a help in residency, 73% replied a great deal, 27% moderately, and 0% none at all. As to whether general practice was a help in practice, 78% answered it helped a great deal, 22% felt moderately, and 0% thought it of no benefit. Eighty-one per cent of those polled would recommend all graduates do some general practice to gain experience, but 9% thought this nonessential. As to present attitudes toward general practice, 61% considered it an integral component of American Medicine without reservation, but 35% stated substantial improvement necessary.

Opinions were requested as to how the number of general practitioners could be increased. Space does not permit the separate listing of the 27 different ideas. The principal ideas were increased general practitioner participation in medical schools, increasing the postgraduate training period, teaching the value of the general practitioner in our medical schools and encouraging general practice before specialty training.

It is hoped that these results will delineate those elements of specialty practice which make it more desirable. By creating programs for training competent family physicians stressing these positive factors, the shift toward specialty training may be brought to an end.

III. Recommendations for Work of Next Year's Committee

Citing the deteriorations of health care which must accompany the decline of general practitioners and a concomitant rise in cultists, the general practice committee should continue its active interest and participation in the Kentucky Programs. The University of Kentucky program as planned is a national leader. To further elucidate the problem, it would be of great advantage to ascertain more accurately the number and availability of general practitioners in each community of the state.

The chairman wishes to exercise his prerogative to express his sincere thanks for the efforts and labors expended by an excellent committee.

Recommendations, Reference Committee No. 2

The Reference Committee considered the report of the General Practice Committee with Doctor Homer B. Martin as chairman and approved the report with the suggestion that in addition that private hospital internships be encouraged in order to increase the number of physicians in general practice.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded and carried.)

Hospital Committee, James B. Holloway, M.D., Lexington, Chairman

The Hospital Committee met twice in this last year, once in October of 1963 and again in May of 1964. In addition to that there have been a number of "Dry Run" Committee meetings, "Dry Runs" at hospitals, and several trips by the Chairman of the Committee to Eastern Kentucky regarding the Appalachian Regional Hospital situation. Items to be discussed are:

1. The accomplishment of the Kentucky State Medical Association Staff and the Kentucky Hospital Association in getting up a manual for "Dry Run" Groups consisting of two parts. (a) A part sent to the hospital preparing for a "Dry Run". (b) A part to the "Dry Run" members. This has been an accomplishment by our technical staff and by the Kentucky Hospital Association and is to be commended. The book will be invaluable in coming years for those who are on the "Dry Run" Committees for the first time.

There was one "Dry Run" in Western Kentucky, another at Columbia, Kentucky and lastly one at Cardinal Hill in Lexington, Kentucky. The "Dry Run" at Columbia, Kentucky resulted in the Committee advising the hospital not to, at the present time, apply for accreditations since they were not ready. This has saved some embarrassment on the part of the hospital and the community as I feel sure they wouldn't have made the grade. The "Dry Run" at Cardinal Hill in Lexington has not been done at the time of writing. The details of the "Dry Run" in Western Kentucky are not available to me as it was done by the group from Paducah.

2. The Committee has perused with interest the AFL-CIO Policy Statement on Hospitals and agrees with the platitudes vouchised therein but we most emphatically disagree with their attitudes of interfering in the management of the running of hospitals.

AN AFL-CIO POLICY STATEMENT ON HOSPITALS

I. The Growing Importance of Hospitals

Hospitals have become agencies of vast importance to the American people, including the 45,000,000 men, women and children who are members or in the families of members of the AFL-CIO. Many of our grandparents regarded hospitals as places only for the poor, places to which people rarely went except with the expectation to die. Now we all consider hospitals as centers of healing, in which most of our babies will be born and in which we can obtain the ever-advancing benefits of scientific medicine, made possible by the technical facilities, the trained personnel and the careful organization of all these, assembled in the hospital.

While much essential medical service is rendered in doctors' offices, in clinics and in patients' homes, nevertheless the hospital is more and more becoming the center for the advancement of medical science and the application of its powers for the benefit of human beings.

The remarkable development of hospitals* has taken place since the beginning of the present century. In the last fifty years, the number of hospitals in the United States has grown 50%, but the number of hospital beds has increased over 400%, twice the rate of the growth in population. The growth has been in quality as well as in quantity. The hospitals of today are vastly more effective in diagnosing and treating disease than they were a half-century ago. They cost more, but private and public expenditures have risen to the challenge. The private initiative and public spirit of physicians and laymen; the devoted unpaid services of many men and women, and the advancing policies of local, state and national governments have brought about this noteworthy advance via the availability and effectiveness of hospital care.

Along with the immense benefits to the people from this progress, certain disadvantages have appeared. It is important to understand and to remedy these disadvantages so far as possible. The professional men and women who provide services in hospitals, the twenty million Americans who use hospitals annually and the 185 million who may use them are all deeply concerned that these remedies be found and applied. No one has a greater concern with the accessibility of hospital care and with the high quality of that care, than the people whose health and lives are at stake, or at any time may be at stake, as patients in hospitals.

Professionals who provide services and those who administer hospitals may declare that patients who receive care cannot usually judge its quality. Organized groups of consumers (Potential Patients) can however, directly or through qualified staffs, appraise many of the elements of quality. The attitudes of patients, their reactions to hospital conditions and services, and their sense of satisfaction or dissatisfaction are highly important. There is widespread feeling that hospital service has become so highly specialized and the personal care of the patient divided among so many different people, that many patients experience no sense of receiving attention as persons; a situation not fully compensated for even by alert attention to the disease.

Let us, therefore, with full appreciation of the skill of our professionals, proceed to state the disadvantages which our experience as patients and potential patients find in hospitals today, and then present our suggestions for remedy.

II. Present Problems and Difficulties

First: The Large and Progressive Increase in Hospital Costs. We appreciate that the benefits of modern medicine cannot be obtained without vastly more elaborate and expensive equipment than formerly, and without a larger number of highly trained professional and technical personnel. Many valuable services which were formerly unknown must now be performed in hospitals. The vast benefits of surgery are possible only through hospitals. Nevertheless, the rise in costs of hospital care has not only been at a greater rate than any other important item in the American family budget, but also at a higher rate than the increase in incomes of a large part of our population.

Second: Hospital Growth Without Community Planning. We are concerned about the large number of hospitals that have grown up in many cities and their suburbs, a few governmental, most non-profit, some profit making; established each for itself, usually enlarging each for itself, without any general plan that would relate the number and locations of hospital beds to what expert opinion judges the area needs or is in future estimate to need. Hospital facilities and services are now too expensive to grow unplanned.

Third: Too Many Small Hospitals, which cannot provide the quality or the range of specialist services which some patients require, and which, either in large cities or in small communities, do not have relations with larger institutions for cooperation in the diagnosis and treatment of such patients.

Fourth: Despite the large and costly increase in hospitals for acute short-term illness, there are *serious deficiencies in facilities* for other great and growing needs; especially: for chronic illness; for patients who can be adequately served in a nursing home rather than in the more costly hospital; for organized plans for care in the patient's home.

Fifth: Insufficient Use of the Diagnostic and Treatment Facilities of the Hospital for Ambulatory Patients, that is, those who can come and go on their own feet for medical attention, without the expensive stay in a hospital bed. The policies of most voluntary non-profit hospitals differ sharply as between bed and ambulatory patients. These hospitals generally accept all economic groups, from the wealthy to the destitute as bed patients; whereas ambulatory patients are usually accepted in the "outpatient department" only when they cannot afford to pay a physician. A majority of these hospitals have no organized provision for ambulatory patients except in an "emergency room."

Sixth: Lack of Assurance to the Patient of Quality of Hospital Care. Quality of care is promoted by the voluntary system of hospital inspection and accreditation, maintained by national professional organizations. Notwithstanding, only about 60% of our 5,500 general hospitals are accredited. Most of the larger hospitals meet the standards and are accredited; only a fraction of the small hospitals are. Few patients are made aware whether a hospital to which they are referred is accredited or not.

Seventh: Deficiencies of our Hospital and Medical Insurance. We have all benefitted by the growth of "health insurance," and we are all indebted to the professional and lay groups which have pushed health insurance plans forward. We are, however, more and more aware of the limitations of most present health insurance plans. These limitations appear from both the medical and the economic points of view.

Medically: Although over 125 million persons are "reached" by some form of health insurance, only a small fraction of these obtain from it a broad scope of curative and preventive services. Economically: Hospitalization insurance, taking non-profit and commercial types together, covers only a little more than half of our total hospital bills; insurance for the services of physicians and surgeons, a much smaller proportion.

About fifty million Americans—mostly among the aged, the rural people and the low-income but self-supporting families in the cities—have no health insurance at all. Thus many who especially need it do not get it.

**This statement refers to the general hospitals and does not include the very large group of specialized hospitals for mental illness.*

The majority of existing health insurance plans are open to abuses which add to costs; they are not organized so as to control or promote quality of care; and they make no provision for preventive services.

Eighth: Insufficient Development of Group Medical Practice. We believe that the vast majority of Americans desire to have the full benefits of modern medicine—diagnostic, curative, preventive and rehabilitative. We are confident that most of the American people would prefer to pay for these benefits on the insurance principle, so that they can put all or most of their expenses into a regular family budget; instead of having to meet unpredictable and often burdensome costs, as is common when fees must be paid for each service. The experience of a number of insurance plans in this country, serving now a total of over four million persons, has demonstrated that when physicians are organized in well-balanced groups and utilize facilities and auxiliary personnel under unified administration, the patient can obtain relatively comprehensive care with the maximum economy. He will have the medical advantage of continuous contact with a personal physician as well as with specialists, and the financial advantage of systematic pre-payment.

Therefore, we desire to see prepaid group medical practice encouraged by voluntary and legislative action. Present obstacles to its development should be removed, especially (1) laws in some states which restrict group practice, and (2) acts by some hospitals and medical societies which restrict hospital privileges for physicians who join group practice units.

Ninth: Lack of Participation of Those Who Use and Pay for Hospital Care in shaping the social and financial policies of hospitals. The same may be said of Blue Cross plans. There are some hospitals and some Blue Cross plans which demonstrate the advantages of such participation. Yet in the main, hospitals and Blue Cross plans are run from the approach of the providers of service. A better balance between consumers and providers is desirable.

Tenth: A Low-wage Policy affecting more than a half-million nurses and non-professional employees is prevalent in many hospitals. The right of the employees of non-profit hospitals to organize for collective bargaining is not protected by Federal law, as it is for workers in industry. Only a few states provide such protection through state laws.

Eleventh: Some Hospitals Discriminate against the admission of patients or in the facilities provided patients, *because of race or color;* and for the same reason, against the admission of certain physicians to the privileges of their medical staffs.

Twelfth: Failure to Utilize the Powers of Government Constructively to deal with some important problems, specified on pages 9, 10 and 11. American hospitals and American medical practice are predominantly non-governmental. We do not propose a governmental system. We do perceive—and mention later—problems which have not been dealt with successfully by voluntary action, and which we do not believe can be.

III. Recommendations for Community Action

Viewing these matters, the AFL-CIO Executive Council has concluded that organized labor throughout this country should give vigorous attention to the improvement of our hospitals in their effectiveness and their economy. We have therefore prepared the following statement of policies and proposals. It is our hope that these policies and proposals will be implemented in practical ways, by other public-spirited agencies.

A. *PLANNING.* No hospital should be built, enlarged or re-located except in accord with a systematic plan of estimated present and future needs for hospitals and allied agencies; a plan prepared by a representative non-profit agency, enlisting the services of impartial experts should be understood to include not only physical facilities, but also services. Every proposal for expansion, brought forward by individual hospitals or others should be evaluated according to the needs defined in the plan—needs not only for beds for acutely ill patients, but also for facilities for long-term patients, for nursing homes, for home care, for ambulatory facilities, for rehabilitative facilities, for facilities for research and education of professional and technical personnel.

Our communities, their surrounding areas and their needs have become so large and complex, and the costs of medical facilities have become so high, that we cannot afford the inefficiencies and the costs of unbridled individual autonomy. Persons and institutions have an obligation to discipline their autonomy in terms of their obligations to their community.

In a few states and in a number of localities, planning councils have already been set up by public authority or voluntary action. In every state there is a hospital council to administer grants for construction under the Hill-Burton Act. Obviously any legislative or voluntary action for state and local planning should take existing councils into account: utilizing, combining, or coordinating the agencies already established. It will be advantageous when the state and local health departments can give leadership in planning. State programs providing hospital care for dependent persons through welfare or health departments can aid in making planning effective.

We recommend that in every State there should be a Hospital Planning Council under this or an equivalent title established by voluntary or public action, or by a combination of voluntary and public action. A majority of the governing body of the Council should be made up of carefully selected and interested persons from all important sections of the general public; the other members to be physicians and other professional persons from different branches of the health field. Similar local or regional bodies should be established, as rapidly as practicable, each covering a major community or hospital service area.

We believe that experience has demonstrated that planning bodies for hospitals are ineffective unless they are able to influence substantially the individuals, organizations, and public agencies from which capital funds for hospital development must be obtained. Financial sanctions are often necessary to bring institutions and agencies to comply with the requirements of a community plan.

B. *CONTROL OF COSTS IN RELATION TO PLANNING.* A plan which includes within its scope all the varied institutional and other facilities needed by present medicine for the diagnosis, care and prevention of disease must also take into account the widely varying costs of these facilities, both as to capital investment and as to operation. A community plan will therefore include methods for guidance and where necessary for controls, for two main purposes:

1) Distributing patients to those facilities which will meet their medical needs at the minimum cost consistent with medical effectiveness;

2) Controlling utilization of hospitals so as to minimize use not medically necessary and to encourage as much use as is necessary.

Methods of guiding and controlling hospital utilization have been developed in some institutions. Their application should be made general instead of spotty. Community organization, supported by organized labor, employers and other who pay hospital bills is necessary to accomplish this with the cooperation of physicians and allied professional persons. The largest contribution towards keeping hospital and other medical care costs within bounds, yet meeting good professional standards, will be found by utilizing the most expensive type of facility—the hospital bed for acute short-term cases—only for such patients as need such intensive care and only for so long as they do need such care. More extensive provision and use of other bed facilities and of ambulatory services are necessary also. Such a goal, we believe, can be reached only when informed members of the general

public participate in an organized way with physicians, hospital administrators and other professionals of the health field.

C. *MAINTAINING AND PROMOTING QUALITY OF CARE.* The present voluntary system of standards, inspection and accreditation, under the auspices of the Joint Commission on Accreditation, should be more widely understood by the general public as a guide to individuals in their use of hospitals and should be fully utilized by these agencies which are important sources of funds for the current expenses of hospitals. We recommend:

1) Accreditation ought not to be limited because of small size of hospital. The Joint Commission on Accreditation and State and local Planning Councils may well consider the standards and the regional relations which should be required of small hospitals.

2) The Joint Commission and its sponsoring bodies should distribute widely information about hospital standards, and how they are maintained in terms understandable by the general public; should cooperate with voluntary and public agencies in so doing; and should make readily available in every locality the names of the hospitals on its accredited list.

3) Public funds paid to hospitals for the care of "Welfare Patients" should be paid only to accredited hospitals, except in cases of emergency or when no accredited hospital is within reach. Organized labor and civic bodies should push for the adoption of this requirement by administrative action when possible and should seek State Legislation when necessary.

4) Every effort should be made as public understanding of the importance of accreditation increases—

a) to persuade Blue Cross and other insurance plans both non-profit and commercial to adopt the policy enunciated above, either on a voluntary basis or by action of the State Insurance Commissions, and

b) to persuade labor and management to follow this policy in their collectively bargained health insurance programs.

D. *INSURANCE.* The extensive experience which organized labor has had with voluntary insurance plans of different types leads us to recommend that Unions in negotiating collective bargaining contracts or in arranging for health insurance in other ways, should select or arrange their insurance according to the following priorities:

1) Plans in which physicians' services are provided through group medical practice;

2) *Plans which provide relatively comprehensive services,* from physicians and surgeons as well as from hospitals, as contrasted with plans which provide or pay for only restricted services;

3) *Insurance plans which provide services,* or which assure payment for services, rather than plans which provide cash indemnities only.

E. *CONSUMER REPRESENTATION OF GOVERNING BOARDS.* The power structure of the majority of non-governmental general hospitals centers in its medical staff, mostly physicians who derive an important part of their income from the care of private patients in the hospital. Naturally, they tend to be more concerned with the interests of the expansion of particular hospitals than with community planning for all hospitals and allied institutions of the area. The majority of hospital governing boards, although possessing full legal authority, have not provided sufficient weight for the community interest. Organized labor should be active in an endeavor to supply a better balance in favor of the community. We recommend:

1) Organized labor and other groups interested in community betterment and community planning should seek adequate representation on hospital boards.

2) Blue Cross has from its beginning been managed mainly by those who provide services with insufficient or no representation of the direct interests of the subscribers, who use the services and who pay for them through insurance plans. We believe that such non-profit plans should be managed by boards, the majority of whose members represent the workers and employers who are subscribers, and who have a direct concern with the scope, economy and quality of the services, with a minority of the governing body composed of those who represent the providers of service. Every effort should be made by the workers and employers who have a financial or personal stake in these non-profit plans, to bring about this essential change in their management, proceeding through discussion and negotiation so far as practicable; through legislation if necessary, or through setting up new plans, properly organized.

3) Unions should undertake systematic education of selected members and officers in the problems of hospitals and health insurance plans, in order that there may be a pool of men and women competent to serve effectively as board members.

4) Pooling action by unions: Local unions, with the encouragement and aid of their state and national bodies, should unify their policies and pool their efforts in dealing with hospitals, physicians, Blue Cross, Blue Shield, insurance companies, or with organizations representing these bodies. Rates, benefits, conditions of eligibility, abuses and problems of administration are all subjects in which common policies and the pooling of bargaining power will be of advantage.

F. *COLLECTIVE BARGAINING FOR HOSPITAL EMPLOYEES.* Although the non-professional employees of non-profit hospitals have the right to organize in unions, they do not have (except in a few states) the same legal protection in exercising this right as do employees in industry. We believe that non-professional employees of all hospitals including non-profit hospitals, should have the same legal protection to organize and bargain collectively as do employees in industry, and that if they were met in a spirit of cooperation by hospital management both groups would benefit. We should like to see progress made towards this goal by negotiation. It must be attained by legislation, if necessary.

G. *RACE DISCRIMINATION.* Discrimination against any patients or segregation of patients because of race or color is a blot upon America. This is equally so in the utilization of physicians and in granting staff privileges to physicians. Such discrimination is especially obnoxious when practiced by agencies legally dedicated to community service. The only ground for exclusion of a physician from hospital staff privileges should be lack of professional competence to perform the services required of him in the hospital.

We urge unions in every locality to take steps and to support other agencies in taking steps, to bring an end to such discrimination, by friendly representations, by legal action under existing laws, or by new legislation.

We recommend that the Joint Commission on Accreditation include non-discrimination against patients or physicians in its requirements for accreditation.

We recommend that the Hill-Burton Act be amended so that federal grants under this act be forbidden to any institution practicing discrimination because of race or color.

IV. Recommendations for Legislative Action

A. *CONSTRUCTIVE USE OF GOVERNMENTAL POWERS.* Many of the preceding subjects have included reference to administrative or legislative action by local, state or federal Governments. Voluntary action in past years, sometimes in conjunction with governmental action, has done much to develop our hospitals, to elevate the quality of hospitals and of the work of their staffs; but it has allowed wide divergencies in standards and in levels of performance to grow up and to persist.

In a country with the human and economic resources of the United States, there is no room for second-class standards in dealing with the health of

human beings. There are many problems and deficiencies which we do not believe can be dealt with by voluntary action alone. Voluntary action has rarely been able, for example, to control the establishment and location of hospitals according to rational plans based on area needs and financial economy. It has failed to apply finely established standards of quality to large numbers of hospitals. It has not succeeded in gaining general adoption of uniform minimum standards of hospital accounting and statistics. We believe that carefully considered legislative and administrative action by governments, designed in cooperation with the professions and institutions concerned, is essential to improve conditions at these and other points.

We recommend:

1) The establishment of an organization for planning hospitals and allied facilities at State, regional and community levels, through governmental or voluntary action, or a combination of these.

2) The enactment in every State, of a law requiring all hospitals to make annual reports of their finances and services to a State Body, according to forms provided by that Body; the reports to be publicly available. A few States have such laws now.

Payments to hospitals by governmental bodies, by insurance plans and by other agencies besides individual patients are now a large and sometimes the major part of hospital current income. Since it is generally accepted as reasonable that such payments should be on the basis of cost of care, it becomes of the first importance to be able to determine what the cost is. Uniform financial and service reports are essential to making that determination in a manner that minimizes inaccuracies and disputes and safeguards against setting payments by arbitrary authority. The American Hospital Association has for many years made authoritatively prepared report forms available to all hospitals, but their adoption is far from general. A simple law such as is proposed would be an aid to good management, not an interference with management.

3) Amend the hospital licensing laws which now exist in all states; so as to include provisions for minimum standards of service, organization and records; instead of, as is usual at present, relating chiefly to the safety and fire protection of the physical facilities.

For organization, service and records, the standards of the Joint Commission on Accreditation provide a sound base; but since the technology of the health field is advancing rapidly, details of standards should be left to regulations rather than be frozen into statutes. Each state must determine for itself whether the Health Department or some other agency shall administer the hospital licensing laws. When enacting such laws, care should be taken to obtain appropriation of sufficient funds for adequate inspection and enforcement. The practical problems of inspection and enforcement focus on the unaccredited hospitals; though of course, the law must apply to all.

3a) To provide for small hospitals in isolated communities, the state licensing law should be adapted so as to require standards appropriate to such institutions. The state-wide hospital plan should include provisions that whenever possible, patients who need diagnosis, surgical or other treatment which the small hospital cannot provide, should be admitted or transferred to a hospital which has the facilities and the specialized personnel required.

First-rate hospitals apply to their medical staffs the principle that each physician on the staff is limited to provide only those services which in the judgment of his professional colleagues he is competent to perform. The same principle should be utilized for hospitals as such.

4) Abolish existing laws in many states which prevent or restrict insurance plans which are associated with group medical practice, or are organized under the auspices of the consumers of services. Enact instead, enabling laws safeguarding the right to establish such plans, with due protection for the professional and public interests involved.

There is no justification for depriving Americans of the right to establish insurance plans of their own choosing, subject to general state laws affecting all insurance plans; or their right to make mutually satisfactory arrangements with physicians or groups of physicians, or hospitals, to supply services to the members of such plans.

5) Provide for federal low-cost loans towards the initial costs of building and equipment of non-profit group practice plans.

6) Provide hospitalization and allied insurance for the group in our population which most need it and which now has the least of it—*the aged;* through distributing the costs over the working life of the individual, according to the social security principle which has been so successfully applied to the maintenance of income during old age.

The voluntary plans, both non-profit and commercial, offer various levels of insufficient hospitalization benefits to persons over 65, at costs not less than $100 to $150 per year. Such costs are obviously beyond the means of a group wherein two-thirds have annual incomes of less than $2,000 (including the incomes of married couples), and 30% with incomes of less than $1,000. America cannot tolerate public charity as the only resource available to its people when they grow old and are sick. The social security principle provides a method of financing consistent with self-respect and economy. For that fraction of the aged who have more adequate incomes, voluntary insurance will have excellent opportunity to offer supplementary insurance.

7) Effect, through administrative action by state and local authorities, or by legislation when necessary, the principle that *payments by government agencies to hospitals,* for the care of patients for whom a public agency is responsible, shall be *on the basis of full cost of service, reasonably determined.* At present there is wide divergency from this principle in many localities.

8) Amend the Hill-Burton Act so as to make the following improvements (subject to provisions made in legislation for general state planning councils as suggested previously):

a) Prevent discrimination by race or color, through preventing future use of so-called "Separate but Equal" accommodations for Negro and White groups.

b) Provide that no existing or proposed hospital may receive a Hill-Burton grant unless it meets the requirements of the state-wide plan, and of its community or regional plan.

c) Require that the state hospital councils shall have majority membership representing the public, a minority the providers of service.

V. Putting Recommendations Into Effect

In order to translate the preceding policies and recommendations into action, labor bodies and cooperating public-spirited groups need blueprints as well as goals. Many of the proposals regarding planning agencies, composition of governing bodies, specific provisions of legislation, etc., need to be worked out with expert advice from various sources, and to be flexible enough for adaptation to diverse local conditions. The AFL-CIO must give leadership in moving from ideas to realities.

The Community Services Committees of AFL-CIO State and local labor councils and local unions should endeavor to enlist other public-spirited groups to cooperate in effectuating these proposals concerning hospitals and the associated medical care problems.

The most important area in which advice is needed is the medical area. Advice and guidance from experienced and socially minded physicians are essential

both in reaching sound conclusions of many matters and also in gaining public recognition and support.

We therefore recommend that the AFL-CIO establish a Medical Advisory Committee to give guidance and counsel on these related matters.

This statement was developed by the National Advisory Council to the AFL-CIO Community Services Committee at the suggestion of the Community Services Activities staff and drafted by a Committee of the NAC which included Dr. Michael Davis, Chairman, Dr. Berwyn Mattison, Mr. Philip Bernstein and Mr. Whitney M. Young, Jr.

Adopted by the AFL-CIO Community Service Committee
February 1963
Approved by AFL-CIO Executive Council, Bal Harbor, Florida
February 1963

3. The most pressing and continuous business before the Hospital Committee has been the Appalachian Regional Hospital situation. The most important facet of this is that a Special Committee has been formed to investigate the methods of practice in Eastern Kentucky and this has relieved the Hospital Committee of considerable burden along these lines. No general statements can be made about the hospital situation but I will make a brief report in a paragraph about each.

A. Hazard—There are no doctors practicing in the hospital. The two former Mine Worker employees who remained in Hazard are in private practice and belong to the State Medical Society and the situation in Hazard as far as the Hazard Appalachian Regional Hospital goes is a happy one.

B. Middlesboro—There are still at the present time four doctors practicing within the walls of the Middlesboro Appalachian Regional Hospital. But plans are afoot to build a building on the grounds which will be sold or given a long time lease to a separate corporation. This building will be large enough to house a number of doctors from town as well. As long as these plans don't bog down the situation in Middlesboro should resolve itself.

C. McDowell—A number of doctors are practicing within confines of the hospital. There are no plans to move them at the present. There are no strong movements afoot to do anything about this because of the isolation of McDowell. Time will take care of this one way or another.

D. Harlan—The Daniel Boone Clinic is still practicing within the confines of the hospital. The local physicians have made no strong objection. The Daniel Boone Clinic dominates the Harlan area and belongs to the County Medical Society. They have long term plans to move from the hospital, but the situation as regards to the viability of the Daniel Boone Clinic is so fluid at the present that no plans are under way.

E. Whitesburg—This has been the most complicated problem and the Chairman of the Committee has made two visits to Whitesburg to try to help straighten it out. At the present time there are three physicians practicing within the confines of the hospital. Two are members of the Daniel Boone Clinic and one a member of the Whitesburg Clinic which is controlled by Dr. Musgrave from Jenkins. The two private practicing physicians in town are anxious to get everybody out of the hospital, but an inspection of all available sites revealed there is no satisfactory site in Whitesburg for more than one doctor's office. The Daniel Boone Clinic is moving in either three or four more doctors this summer. Tentative plans are under way, however, for construction of a building near the hospital by private funds. This drive has just gotten under way and is so tentative it is to be still nebulous.

F. Pikeville—Pikeville will pass into the hands of the Appalachian Regional Hospital Groups in July. Only two former members of the Mine Workers Fund are going to stay in Pikeville. They are moving out of the hospital, but temporarily into a building on the grounds. However, plans are afoot to construct a large building to house all the Pikeville doctors and they are going to go into this building. So I am hopeful that things will do well.

G. South Williamson—Don't know much about this situation. A group practice is being planned and they are going to stay in the hospital. They are orientated to West Virginia although residents of Kentucky.

Council on Medical Education and Hospitals
Walter S. Coe, M.D., Louisville, Chairman
James B. Holloway, M.D., Lexington
Walter I. Hume, Jr., M.D., Louisville
George A. Sehlinger, M.D., Louisville
Donn L. Smith, M.D., Louisville
William R. Willard, M.D., Lexington

Recommendations, Reference Committee No. 2

The Reference Committee considered the report of the Hospital Committee by Doctor James B. Holloway and approved this report in its entirety. Your Reference Committee is aware of the great amount of time expended and personal sacrifices made by Doctor Holloway and wishes to express its appreciation for his splendid leadership.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried.)

Resolution C
Jessamine County Medical Society

WHEREAS, many hospitals, especially those associated with teaching institutions, have in recent years instituted in increasing numbers straight internships, and

WHEREAS, such straight internships fail to give the young trainee a well-rounded preparation for the practice of medicine and/or surgery, and

WHEREAS, such straight internships completely fail to provide an opportunity to prepare for general practice, therefore, be it

RESOLVED, that this 1964 House of Delegates go on record as opposing straight internships exclusively* and recommend the institution of well-coordinated, rotating, in-hospital internships of two years' duration, and be it further

RESOLVED, that we instruct our delegates to the American Medical Association House of Delegates to present a similar resolution to that body and to exert all due influence toward the achievement of this goal.

Recommendations, Reference Committee No. 2

The Reference Committee considered Resolution C introduced by the Jessamine County Medical Society concerning Straight Internships vs. Rotating Internships and approved this Resolution as corrected on the floor of the House of Delegates.

Mr. Speaker, I move the adoption of this resolution. (The motion was seconded and carried.)

**The first resolved of this resolution originally read "Resolved, that this 1964 House of Delegates go on record as opposing straight internships per se and recommend . . .". At the first session of the House, the delegates from Jessamine County asked that the word exclusively be substituted for "per se".*

Resolution D
Campbell-Kenton County Medical Society

WHEREAS, the American Medical Association has declared itself in favor of private hospital internships and

WHEREAS, the American Medical Association has also declared itself in favor of individuals entering the general practice of medicine, and

WHEREAS, teaching hospital internships tend to guide students to the specialties instead of General Practice and

WHEREAS, as a result of the action of the Council on Medical Education there has been a reduction in private hospital internships both regionally and nationally, and

WHEREAS, it therefore appears that the Council on Medical Education continuously repudiates the policy of the House of Delegates of the American Medical Association, therefore be it

RESOLVED, The Kentucky Medical Association enlist the aid of the other 49 states to influence the House of Delegates of the American Medical Association to direct the Council on Medical Education to alter its policy to conform to that set forth by the American Medical Association and to encourage private hospital internships.

Recommendations, Reference Committee No. 2

The Reference Committee considered Resolution D which was introduced by the Campbell-Kenton Medical Society on the subject of Private Hospital Internships. While the committee agrees in principle with the Resolution, it would like to recommend the following substitute resolution:

WHEREAS, the American Medical Association has declared itself in favor of private hospital internships and

WHEREAS, the American Medical Association has also declared itself in favor of individuals entering the general practice of medicine, and

WHEREAS, teaching hospital internships tend to guide students to the specialties instead of General Practice and, therefore be it

RESOLVED, The Kentucky Medical Association enlists the aid of the other 49 states to influence the House of Delegates of the American Medical Association to direct its Council on Medical Education to encourage private hospital internships.

* * * * *

Mr. Speaker, I move the adoption and implementation of this substitute resolution. (Motion seconded; carried.)

President's Report
(Paragraph numbered two, page 3)

2. A growing movement in the Area Hospital Planning. This has a great potential for public service, if appropriately guided and kept on a voluntary basis. We must resist all efforts to make it a compulsory movement. We specifically recommend KSMA participation at every opportunity.

Recommendations, Reference Committee No. 2

Paragraph #2, page 3 of the President's Report was reviewed by our Committee. Your Committee wholeheartedly endorses this recommendation and recommends its implementation.

Mr. Speaker, I move the adoption and implementation of this resolution. (Motion was seconded and carried.)

President's Report
(Paragraph numbered 7, page 4)

7. Our Hospital Committee and each individual doctor must take time to inform the many new and old hospital trustees throughout the state of their responsibilities, question them on what kind of job they think they are doing, and do they feel generally satisfied with their policy formulation in their boards. Subjects to talk on are: (1) trustee orientation, (2) trustee education, (3) board/medical-staff relationship, (4) hospital-personnel relationship, (5) public relations, (6) community relations.

Recommendations, Reference Committee No. 2

Your Committee considered this recommendation carefully and feels that it is an excellent recommendation and recommends its approval and implementation.

Mr. Speaker, I move the adoption and implementation of this recommendation. (The motion was seconded and carried.)

Mr. Speaker, I move the adoption of Reference Committee No. 2 as a whole. (The motion was seconded and carried.)

The Chairman of Reference Committee No. 2 would like to express his appreciation for the cooperation of the members of his committee and the views presented by those doctors attending the meeting.

REFERENCE COMMITTEE No. 2
W. Gerald Edds, M.D., Calhoun, Chairman
Richard A. Allnutt, M.D., Covington
Walter L. O'Nan, M.D., Henderson
Robert A. Orr, M.D., Mayfield
Samuel D. Weakley, M.D., Louisville

REFERENCE COMMITTEE NO. 3 †

Homer B. Martin, M.D., Chairman
Reports on Legislative Activities

† *See note (†) bottom of column one, page 962.*

Reports considered by this committee were:
13. Council on Legislative Activities Report
15. Report of Council on Communications and Public Service
16. Report of Council on Allied Professions and Related Groups Resolution B

Report of the Council on Legislative Activities

PREFACE

Procedures for reports of councils and standing committees of KSMA to the House of Delegates are provided for under Chapter VII, Section 4 of the By-laws, which reads in part:

". . . Each standing committee and council shall report annually, at least six weeks prior to the Annual Meeting to the House of Delegates via the Board of Trustees, respecting its activities during the year last past. These reports shall be transmitted without alteration or amendment to the House of Delegates by the Board of Trustees at the Annual Meeting, with such comments or recommendations as the Board cares to make. . .

The material in this report of the Council on Legislative Activities is presented in the following order:

1. *Actions and recommendations by the Council which it undertook on its own initiative.*
   - *A. National Affairs*
   - *B. State Affairs*
2. *Recommendations by the KSMA Board of Trustees on the overall contents at the conclusion of the report.*

* * * *

NATIONAL AFFAIRS — John C. Quertermous, M.D., Chairman

The Council on Legislative Activities on National Affairs, in submitting this report to the House of Delegates wishes to express its appreciation to the House for the confidence demonstrated in allowing them to serve in this important area in behalf of all the doctors of Kentucky.

The mission of this Council, although becoming more complex and time consuming, is becoming more gratifying because of a significant increase in interest and awareness developing in the individual physician.

The ACTIVITIES of the Council have been productive. We met six times in regular session and one time in Washington, D.C. at the annual Congressional Dinner. There were sixty-one in attendance including eight Congressmen, their wives and staff. Unusual gains were made during this trip, and it is believed that our congressional contacts will be easier in the future because of rapport gained at this meeting.

The Kentucky Chamber of Commerce held a Congressional Dinner in Washington early in April. This was attended by G. L. Simpson, M.D. (a director of the State Chamber), Mr. Joe Sanford, and the Chairman of this Council. This was thought to be productive from the standpoint of cementing relations with this valuable ally, as well as from the Congressmen's standpoint. Mr. Sanford made another series of rounds on Capitol Hill during this trip.

Many physicians were very active in some of the recent primaries and have received grateful acknowledgements from some of the successful Congressional candidates.

Information has been disseminated to the profession through the Legislative Bulletin sent to all Key Men and members of the KSMA Board of Trustees. It is hoped that those receiving the Bulletin will use it to further inform the members of the county societies.

The chief GOAL of this Council is to maintain a situation where the doctor-patient relationship will continue on its present proven successful basis without undue federal government intervention. In order to do this, it is necessary to be continually watchful of bureaucratic attempts to place the financing of medical care of the aging under the Social Security system. It is necessary to keep up our congressional contacts so we will have a voice when our antagonists are successful in bringing a bill to a Congressional Committee or to the floor of one of the houses.

The CURRENT STATUS OF BILLS WITH MEDICAL IMPLICATIONS, with some exceptions, is more reassuring than in the few years past. In the past several months many things have worked in our behalf.

Most important of these is Mr. Wilbur Mills's apparent determination to provide Needed Medical Care at a local level, and outside the Social Security System. He has had important support from Kentucky's Mr. John Watts.

Increases in ordinary social security benefits, with proportionate increases in Social Security taxation, have increased this tax level to nearly ten per cent. This is considered to be the tolerable tax limit for the program at this time. Congressman Mills and his Committee are presently drafting a bill to provide further, and better coordinated, medical benefits along the lines of the Kerr-Mills plan (which Kentucky has shown to be workable). The Council urges every physician to participate in this program because it believes that this plan and its future ramifications will be the weapon we need to forestall frank socialization of medicine.

The Chairman of this Council believes that this planning would not be in process by the House Ways and Means Committee without signal from the President who needs some advertisable change in the current medical financing program in order to show, during his campaign, that he has accomplished a medicare program of his own. This should be done with the help and advice of Organized Medicine.

Every session of Congress is besieged with bills to enlarge the scope of medical care of veterans through the Veterans' Administration. At this writing, there are at least twelve bills pending, and they were recently testified to by David Allman, M.D., and Russell B. Roth, M.D., before the House Subcommittee on Hospitals and the Committee on Veterans' Affairs. The following AMA policy was presented:

1. "The best medical care possible should be provided to veterans who need treatment for conditions incurred or aggravated by their military service."
2. "The best possible medical care should be available to any American."

To enlarge on these premises, the veteran who was injured or became ill in the service of his country, or had this injury or illness aggravated by such service has the RIGHT to necessary medical and hospital care for these service-connected disabilities and he should be permitted to name the hospital of his choice as well as the physician of his choice. The VA should not be able to dictate these matters of vital concern to the veteran. Care of non-service-connected disabilities is not proper concern of the Federal Government.

The Veterans' Bills testified to were HR—170*, 171*, 176*, 229*, 469*, 480*, 2581*, 3681*, 3716*, 4164, 5923*, and HJ Res. 326. The bills with asterisks were the ones taken exception to by the AMA as violating the basic premise as stated above.

HR 7851, HR 8426 and HR 9238 are bills that would exempt from the Anti-Trust laws nonprofit blood banks or physicians who refuse to obtain or accept delivery of human blood or plasma from any other blood bank if the refusal is for the purpose of protecting the health of the recipient of the blood or plasma. The AMA testified in favor of these bills.

On June 4 the House Interstate and Foreign Commerce Committee reported favorably HR 3873, which would permit certain owners of fishing vessels to receive free medical and hospital care at Public Health Service hospitals. AMA opposed. HR 8546 and 29 are identical bills to amend the Public Health Service Act and would provide Federal Student Loans to students of optometry. The AMA and the US Public Health Service opposed these bills.

On May 25 the House passed unanimously the Hill-Burton bill providing future appropriations of 150 million dollars for 1965 and up to 180 million dollars for 1966 and 1967. The FDA moved to bar labeling of oil products as "poly-unsaturated," "low in cholesterol" because such labeling may lead people to believe these foods have treatment value.

The number of bills with implications affecting all phases of medicine is astounding and too numerous to treat effectively here. Any physician desiring information on any of these bills is urged to contact the Council or the KSMA Headquarters, which will direct the request to the proper place.

The Council wishes to commend the Staff of KSMA for an excellence in their work that we believe to be unsurpassed in any medical association in the country. We especially commend the recently resigned Mr. Bobbie Grogan for work he has done in behalf of the Council and for the Association. We are gratified by his expressed willingness to use his skills in our behalf in future legislative sessions. Fred Scroggin, M.D., who has been a uniquely qualified and effective chairman of the Council on the State level as well as an invaluable and knowledgeable member of the Council on National Affairs, will be badly missed. We realize his many duties in this and other associations as a member of national committees and boards are pressing.

We are gratified that immediately following the last legislature the Board of Trustees of KSMA cited Doctor Scroggin and Mr. Grogan and others for the valuable services rendered the Association and the people of Kentucky during the 1964 session of the General Assembly. The Council wishes to endorse and reaffirm this action.

After due consideration, the Council has these RECOMMENDATIONS to make to the HOUSE OF DELEGATES:

1. That the Annual Congressional Dinner be held early in the spring of 1965 at a date to be determined by developments between now and then.
2. That ALL MEMBERS OF THE COUNCIL be reimbursed up to $100.00 for their expenses for the trip to Washington for the dinner.

3. That more direct liaison be established between the Legislative Council and the Board of Trustees (or Executive Committee), especially during legislative sessions in Frankfort.

STATE AFFAIRS—F. R. Scroggin, M.D., Chairman

This is my first report to the House of Delegates as chairman of State Legislative Affairs. Robert Shepard, M.D., on orders from his doctor, resigned one year ago, and the Board of Trustees selected me as his replacement. Serving as chairman has been a most interesting and unusual experience. It has been educational as well as time consuming because the legislature was in session during this past January, February, and March.

Although KSMA did not cause any bills to be introduced, it would be a mistake for any member to assume that the Association had a quiet, inactive, and ineffective legislative year. As is the case on the national level, the medical profession always has the fear it will lose more from objectionable legislation than will be gained from passing our own bills.

Having been closely associated with all senators and representatives and the legislative processes in Frankfort, I realize more than ever the importance of physicians' being astute politicians. It ceases to amuse me to hear a doctor say the medical association should pass a bill to do so and so. With some inquiries, we usually find this individual is not even on a conversational status with his own senator or representative.

Until such time as *more* physicians in this state decide to become more active in politics at the precinct, county, state, and national levels, we will never have the influence to pass or prevent passage of legislation. In my opinion we have the framework devised with the legislative key man system to accomplish these tasks. I want to compliment our past state legislative chairman, Thomas P. Leonard, M.D., in 1958, Wyatt Norvell, M.D., in 1960, and Robert D. Shepard, M.D., 1962 for initiating and improving the key man system. Of course, they had the help of the efficient KSMA Headquarters staff.

Even though the key man system is an excellent plan, only about thirty per cent of the key men are effective. Many county medical societies should give more serious consideration to this system and strive to select a willing and able doctor in the future for this position. We cannot expect our KSMA lobbyist to perform miracles and get the legislators to vote to our satisfaction when we are unable to convince our senators and representatives.

We can expect our lobbyist to:

1. Become personally acquainted with the legislators and attempt to develop their confidence.
2. Become personally acquainted with the many individuals in the executive branch of the government and be in a position to get their attention when needed.
3. Get bills drafted KSMA wants introduced.
4. Become familiar with legislative processes and be able to wisely maneuver KSMA bills through the legislature.
   a. Decide which house bills may best be introduced or decide if the bill should be a companion bill and be introduced in both houses concurrently.
   b. Select a legislator (s) to sponsor the bill.
   c. Check bills with legislative research to determine if they are constitutional.
   b. Advise the sponsor(s) to proper timing to push the bill. Avoid conflicts with controversial issues.
   e. Advise sponsor on members supporting and opposing the bill.
5. Keep watch on the nearly 1,000 bills introduced during a legislative session and notify chairman on those with medical implications.
6. Help doctors who come to Frankfort contact their senators and representatives.
7. Keep chairman up to date on status of all bills we support or oppose.
8. Aid chairman in writing legislative bulletins, which are mailed to all key men, trustees, consultants, and others.
9. Talk with legislators constantly and keep doctors back home informed as to how they will vote on medical issues.

This Bobbie Grogan did superbly.

We are grateful to the thirty per cent group of key men who were instrumental in making the past session a successful one. Not a single objectionable bill with medical implications passed the legislature. Some of the more important bills are listed below, along with comments as to their progress.

HB 112 (an act permitting chiropractors to be paid for treating Workmen's Compensation cases) failed to be voted out of House Rules Committee after getting its second reading.

HB 138 (an act permitting chiropractors to participate in the Kerr-Mills Program) was voted unfavorable by the House Public Health Committee. Therefore, it was never considered by the House members.

SB 255 (an act permitting chiropractors to be paid for treating Workmen's Compensation cases) received two readings in the Senate, then returned to Rules Committee which was the automatic procedure. Effective contacts by key men on members of the Senate Rules Committee prevented this bill from coming out of Rules to the floor for a vote.

HB 179 (an act permitting optometrists to participate in the Kerr-Mills Program) passed the House 69 to 13, then was received in the Senate Rules Committee. It looked like this bill had the support needed for passage, but when the chiropractors tried to get it amended in Rules the members decided not to report it out of Committee.

SB 223, as introduced in the Senate, would effectuate policies to provide for the public health and safety from ionizing radiation. Four days before the session ended the chiropractors were successful in getting the Senate Rules Committee to include this amendment, "The Kentucky State Board of Chiropractic Examiners shall enforce rules and regulations within the profession necessary to effect compliance with state and federal regulations on ionizing radiation." This amendment would take chiropractors out from under the control of the State Board of Health. The bill as amended was killed in the House Rules Committee the day following its passage in the Senate.

HB 483 (an act relating to Workmen's Compensation) passed the House and was received in Senate Rules Committee. The chiropractors made a desperate effort to amend this bill in Rules just one day before the session ended. The amendment in effect would have been the same as passing HB 112 or SB 255. They were unsuccessful with the amendment in the Committee, and when HB 483 came to the floor for a vote, Senator Gardner, Majority Floor Leader, moved the previous question and kept off any proposed chiropractic amendments.

HB 464, as introduced in the House, would amend the present law to enable podiatrists to enter into medical service plan corporations operating in the counties in which they reside or practice. This bill did not get out of House Rules Committee for its first reading.

SB 31 was an education bill pertaining to sick leave for teachers. The chiropractors were successful in getting the Education Committee to add this amendment, "changing the term physician to licensed doctors." This would mean the chiropractors could sign sick leave certifications of teachers. We were successful in getting this bill re-committed after its third reading and just before it was to be voted on in the Senate.

HB 43 (an act which would relieve any physician

who in good faith renders emergency care, from civil damages) was killed in Senate Rules after it had passed the House 72 to 11. Our Council on Legislative Activities was opposed to this bill, or any other bill which would be constitutional, because it would not offer the protection which many physicians might interpret it to give.

SB 225 (an act prohibiting a physician from divulging confidential relations and communications between physician and patient without consent of the patient) was killed in the Senate after receiving two readings. KSMA studied this legislation about three years ago and decided it would not be a good idea to have such a bill introduced. This bill was prompted by a senior medical student's writing Senator C. W. A. McCann and asking that he introduce such legislation.

HB 453 (an act prohibiting any tax from being imposed upon or measured by the premiums paid to or received by hospital service, medical service plan or dental service plan corporations or domestic mutual insurance against risk or cost of medical and surgical care) passed and was signed by the Governor. KSMA supported this bill since it was advantageous to Blue Cross.

SB 65 (nurses bill) introduced in the Senate was never reported out of Committee and placed in the orders of the day for passage.

HB 240 (pharmacy bill) passed the House but was unable to get its first of three readings necessary in the Senate.

SB 8 (dental bill), which was a revision of a dental practice act, passed both houses and was signed by the Governor.

The 1962 House of Delegates requested the Board of Trustees to proceed with a vigorous public education program in regard to cults. The Trustees delegated the responsibility to our Council on Legislative Activities. Our attorney, Mr. Gaines Davis, did extensive research on the authentication of chiropractic treatment and the wording presented in the attached pamphlet was approved by our Council, Board of Trustees, and Council on Allied Medical Services before it was given to the printer. First printing called for 20,000 copies. Physicians have been notified through the Communicator to request the number of pamphlets needed from KSMA Headquarters. Now that the information is in distributive form, we recommend that the Council on Public Information and Service take over and make extensive distribution of the pamphlet.

I would like to thank the Board of Trustees and the Headquarters Staff for their assistance in my appointment to the AMA ad hoc committee on quackery. One meeting has been held, with another scheduled in August. All cults are of interest to this committee, but chiropractic is the primary target. It was with a deep sense of humility that I accepted this appointment, and I assure you that I shall do my utmost to justify your confidence.

Due to serving on the AMA Committee, plus other nation and state committees unrelated to medicine, I find it necessary that I reluctantly resign from this Council. I say reluctantly because I have enjoyed being a member of the Council and closely associated with the other members, who are doctors dedicated to the free enterprise system, including medicine, and who are unquestionably the most cooperative group of physicians with whom I have ever had the privilege to work. The Headquarters Staff has served our Council willingly and well, even though the hours were irregular and long. I cannot thank Bobbie Grogan enough for doing such a magnificent job in Frankfort and helping me get important information disseminated to our legislative key men, promptly. Many senators and representatives told me personally that Bobbie was the outstanding lobbyist in Frankfort. All doctors in Kentucky owe this man a "thank you" vote.

Of course, we cannot overlook the outstanding job Mitchel Denham, M.D., did as Majority Floor Leader while serving as a member of the House of Representatives this year. During my many visits to Frankfort I could see that he was highly respected and had the confidence of his fellow legislators. I think every KSMA member owes Doctor Denham a gratification of thanks.

Recommendation: Because the Board of Trustees is the policy-making body between annual meetings of the House of Delegates, I recommend that the Chairman of the Board of Trustees or the KSMA President be placed on the Legislative Council. Experience from the last legislative session would prove this to be a valuable asset since important final decisions must be made on very short notice. These decisions must have Board concurrence.

Council on Legislative Activities
Branham B. Baughman, M.D., Frankfort
Walter L. Cawood, M.D., Ashland
Hoyt D. Gardner, M.D., Louisville
Daryl P. Harvey, M.D., Glasgow
David B. Stevens, M.D., Lexington
F. R. Scroggin, M.D., Dry Ridge
Chairman—State Affairs
John C. Quertermous, M.D., Murray
Chairman—National Affairs

Recommendations, Reference Committee No. 3

The first item considered by Reference Committee No. 3 was the report of the Council on Legislative Activites.

This is a review of the activities at national and state levels for the past year. We feel that the positions taken by the Legislative Council were representative of the view of organized medicine. The duties of the lobbyist listed in the report are well formulated and constitute a valid guide for our future lobbyist. The results of actions taken by the legislators on the bills enumerated reflect great credit on the planning and actions of Doctor Quertermous, Doctor Scroggin, and members of their Council.

Recommendations: Our Reference Committee considered the recommendations contained in the report and expressed their unanimous approval to continue the annual congressional dinner as in the past. The suggestion to reimburse members of the Council for their expenses to the annual dinner was thought unnecessary by all concerned parties and is not recommended. Further, the establishing of a closer liaison between the Legislative Council and the Board of Trustees was thought essential and is recommended.

Long discussions concerning this report brought out other cogent matters which the Reference Committee wishes to respectfully recommend to the House:

The key man system should be re-examined and revised by the Council to improve the effectiveness of this system beyond the 30 per cent reported. The Council should have greater freedom to select key men of interest, ability, and industry. Organizational meetings of these key personnel should be held far in advance of the legislative sessions when contacts with legislators become more difficult and less effective. In all fairness to the Council, we wish to point out that the key man system does not abrogate the responsibility of the individual member.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried.)

Report of the Council on Communications and Public Service (Paragraph 10, page 6)

(10) The necessity or the lack of it for Good Samaritan Legislation for the Commonwealth should be investigated and determined in the near future.

Recommendations, KSMA Board of Trustees (Council on Communications and Public Service)

This report was reviewed by the Board of Trustees on August 6, 1964.

BOARD ACTION: Approved with the recommendation that the Committee on Disaster Medical Care give no further consideration to the necessity for or desirability of a Good Samaritan Law.

Recommendations, Reference Committee No. 3

The next item was paragraph 10 on page 6 of the Report of the Council on Communications and Public Service. This Reference Committee considered the recommendation of a Good Samaritan Law. After discussion with the Legislative Council and the legal adviser to the Kentucky Medical Association, no need was demonstrated for such legislation.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Report of the Council on Allied Professions and Related Groups (Paragraphs 5 and 6, page 3)

The committee gave much consideration to the way in which the KSMA might work with the members of the nursing profession for the purpose of improving patient care. It reviewed the bill introduced into the 1964 Kentucky General Assembly. Your committee recommends that the House of Delegates authorize the Board of Trustees, as soon after the Annual Meeting as is convenient to be done, to explore with the Kentucky State Association of Registered Nurses and the Kentucky Hospital Association the possibility of making a study leading to the introduction of legislation designed to up-grade and improve the Nurse Practice Act in Kentucky.

COUNCIL ACTION: It is recommended that the report of the Dental-Nurse-Pharmacy Committee be accepted as presented with the exception that the words "Board of Trustees" be replaced by "Council on Legislative Activities" in the last paragraph of the report. The Council further recommends that liaison also be implemented in regard to any legislation which the pharmacists may introduce at the next session of the legislature. This should be well in advance of the next session of the Kentucky State Legislature.

Recommendations, Reference Committee No. 3

The next item was a portion of the report of the Council on Allied Professions and Related Groups.

The recommendation made by the Council was that the Council on Legislative Activities explore with the Kentucky State Association of Registered Nurses and the Kentucky Hospital Association manners of improving the Nurse Practice Act in Kentucky. It was further recommended that the liaison be implemented between the Kentucky Medical Association and the pharmacists.

The Reference Committee approves these recommendations.

Mr. Speaker, I move the adoption and implementation of this section of the report. (Motion seconded; carried.)

Resolution B
Muhlenberg County Medical Society

WHEREAS, we have said it before, but

WHEREAS, there are those who would confuse the issue,

BE IT THEREFORE RESOLVED, that the Kentucky Medical Association is opposed to the extension of Social Security coverage to self-employed physicians.

Recommendations, Reference Committee No. 3

The last item considered was Resolution B, submitted by the Muhlenberg County Medical Society, opposing extension of Social Security coverage to self-employed physicians.

The Reference Committee recommends the following substitute resolve for this resolution: "BE IT THEREFORE RESOLVED, that the Kentucky Medical Association is opposed to the extension of *compulsory* Social Security coverage to self-employed physicians."

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Mr. Speaker, I move the adoption of Reference Committee No. 3 as a whole. (Motion seconded; carried.)

The Chairman wishes to thank the members of the Reference Committee who contributed so unselfishly of their time.

REFERENCE COMMITTEE NO. 3
Homer B. Martin, M.D., Louisville, Chairman
Harold B. Barton, M.D., Corbin
M. C. Loy, M.D., Columbia
James G. Sills, M.D., Hardinsburg
David B. Stevens, M.D., Lexington

At this time, Hoyt D. Gardner, M.D., Louisville, chairman of the Board of Directors of the Kentucky Educational Medical Political Action Committee, made an oral report on the progress of his organization to the second session of the House.

REFERENCE COMMITTEE NO. 4 †

Paul H. Klingenberg, M.D., Chairman

Reports on Public Service and Allied Professions

† *See note (†) bottom of column one, page 962.*

The reports this reference committee considered are as follows:

15. Report of the Council on Communications and Public Service
16. Report of the Council on Allied Professions and Related Groups

Report of the Council on Communications and Public Service

PREFACE

Procedures for reports of councils and standing committees of KSMA to the House of Delegates are provided for under Chapter VII, Section 4 of the Bylaws, which reads in part:

". . . Each standing committee and council shall report annually, at least six weeks prior to the Annual Meeting, to the House of Delegates via the Board of Trustees respecting its activities during the year last past. These reports shall be transmitted without alteration or amendment to the House of Delegates by the Board of Trustees at the Annual Meeting, with such comments or recommendations as the Board cares to make . . . ."

The material in this report of the Council on Communications and Public Service is presented in the following order:

1. *Actions and recommendations by the Council which it undertook on its own initiative.*
2. *Reports of the committees of this Council with the Council recommendations following each committee report.*
3. *Recommedations by the KSMA Board of Trustees on the overall contents at the conclusion of the report.*

* * * * *

The Council on Communications and Public Service has held two meetings during this Associational year on January 23 and July 16, 1964.

We are pleased to welcome the Medicine and Religion Committee which has served under the Council this past year. Our remaining eight committees are: Diabetes, Disaster Medical Care, School Health, Public Health, Senior Day, Highway Safety, Advisory to the Women's Auxiliary, and the Rural Health Committee.

At our first meeting, we had as our guests Mr. William Ramsey and Mr. James Hickox of the Staff of the American Medical Association, who discussed public relations and services available to the KSMA membership from the AMA. At the request of the Council, PR Manuals were distributed from the KSMA Headquarters Office to each county PR chairman or county society secretary.

An exhibit on Medical Careers was presented at the Annual Meeting of the Kentucky School Boards Association in March and again at the Kentucky Education Association Meeting in April. KSMA will also participate in Health-O-Drama at the State Fair this year and a new exhibit on the Emergency Medical Identification Symbol will be presented at the 1964 KSMA Annual Meeting.

Also, at the first meeting, guidelines on the KSMA Orientation Course were submitted to the Bylaws Committee for drafting an addition to the KSMA Bylaws. A Sub-Committee on Orientation was appointed to formulate the methods of implementing the Orientation Course. The Council members approved a statement of the duties for each committee serving under the Council and submitted them to the Board of Trustees for inclusion in KSMA policy.

Other actions taken by the Council and approved by the Board of Trustees included:

1. That the Kentucky State Medical Association endorse commercial advertising under the auspices of the state association and/or county medical societies concerning public service programs in medicine such as emergency calls, house call problems, etc., dealing in good taste with factual medical problems; and
2. That KSMA Trustees send out a letter to new members in their district welcoming them to the Association and offering the services of the KSMA officers and staff.

At its second meeting, the council discussed exhibits sponsored by KSMA and recommends that the presentation of exhibits at the 1965 meetings of the Kentucky Education Association and the Kentucky State Fair be continued as they have been in the past. However, the council recommends that exhibiting at the Kentucky School Boards Association be terminated because of a lack of interest demonstrated by those attending the School Boards' meeting.

The Council discussed Community Health Week which will be held nation wide October 18-24, and approved the concept of this program. It is suggested that an article on Community Health Week appear in the KSMA Journal and that a newspaper release be sent to all daily and weekly newspapers.

It was brought to the Committee's attention that the Council on Legislative Activities had referred the "Some Questions and Answers about Chiropractic" pamphlet to this council for distribution. It is our recommendation that these pamphlets be made available to the members of KSMA for their use by distribution at committee meetings, medical meetings, announcements through KSMA publications, etc.

We again discussed the Mandatory Orientation Program approved by the 1963 House of Delegates and the Council appreciates the efforts of its Sub-Committee on Orientation in drafting guidelines and a tentative program for implementing the Orientation Course. We recommend that the following tentative program as outlined by the Sub-Committee on Orientation be accepted and implemented on the Monday preceding the 1965 KSMA Annual Meeting.

Tentative Program
KMA Mandatory Orientation Course

	Chairman Moderator—To introduce topics & speakers
8:00 a.m.	Registration
8:30 a.m.	Welcome and Introduction — KSMA President Structure — Function — Policies of organized medicine
8:35 a.m.	County (15 minutes—KSMA member or President of one of larger county societies) KSMA (15 minutes—Executive Secretary or KSMA member) AMA (15 minutes—AMA officer or representative or KSMA member)
9:20 a.m.	Public Relations (KSMA member—30 minutes)
9:50 a.m.	Health Insurance (commercial representative—15 minutes)
10:05 a.m.	Health Insurance (Blue Cross & Blue Shield—15 minutes)
10:20 a.m.	COFFEE BREAK
10:30 a.m.	Medical Ethics (KSMA member—30 minutes)
11:00 a.m.	Medico — Legal Aspects (Lawyer — 30 minutes)
11:30 a.m.	Medico—Press Relations (Press, TV, Radio—member of Press—30 minutes)
12:00 noon	Lunch — Sponsored by KSMA (ask wives of candidates — Presentation by President of KSMA's Women's Auxiliary —15 minutes)
1:20 p.m.	Re-registration
1:30 p.m.	Legislation and Political Medicine Legislative Information (AMA Washington Office representative—15 minutes)
1:45 p.m.	Kerr-Mills Bill (KSMA member—15 minutes)
2:00 p.m.	King-Anderson Type Legislation (KSMA member—15 minutes)
2:15 p.m.	KSMA Key Man System—State Legislature (KSMA member—15 minutes)
2:30 p.m.	Question-and-Answer Period or ADJOURN

We further recommend that a Committee on Orientation be formed to serve under this council. We have reviewed and expressed our approval of the addition to the KSMA Bylaws as drafted by the Bylaws Committee pertaining to the Mandatory Orientation Course.

The following reports of the committees serving under this council are herewith submitted:

Diabetes Committee, Robert S. Tillett, M.D., Louisville, Chairman

The Diabetes Committee of the Kentucky State Medical Association scheduled a meeting for June 10; however, it became necessary to cancel the meeting since a quorum could not be present.

Since the promotion of the annual Diabetes Detection and Education Week has remained basically the same since the program was initiated 13 years ago, it is the chairman's recommendation that a similar promotional program be conducted for the 14th Annual Drive during 1964. The Diabetes Detection and Education Drive will be held this year during the week of November 15-21.

We would like to take this opportunity to extend our appreciation to the diabetes chairmen of the county medical societies, all KSMA members, and all of the cooperating organizations that helped us make the 1963 Diabetes Drive the most successful one we have had to date.

During our campaign last November, 96,333 tests were administered and reported to the KSMA Headquarters Office. Of this number, 1,174 proved to be

positive and 191 were newly found diabetics. We are also pleased to report that 95 county diabetes chairmen were appointed and reported to us last year. This enabled us to coordinate the efforts of nearly every county in Kentucky and was one of the prime reasons for our successful campaign.

It is our feeling that the KSMA Diabetes Detection and Education Week is one of our outstanding public service programs and certainly focuses public attention on the Kentucky State Medical Association. Last year our promotional effort resulted in nearly 400 newspaper clippings received in the KSMA Office. We are hopeful that the physicians in Kentucky will continue their cooperation and help make our drives in 1964 and the years to come as successful as the one this past year.

Recommendations, Reference Committee No. 4

The Diabetes Detection and Glaucoma Test at the State Fair has been very successful. Consideration of the Blood Sugar Analysis by rapid finger blood sampling may be considered by this Committee in the future.

Mr. Speaker, Reference Committee No. 4 moves the adoption of the report of the Diabetes Committee as presented. (Motion seconded; carried.)

Committee on Disaster Medical Care, William T. Rumage, Jr., M.D., Louisville, Chairman

The chairman and members of the committee wish to commend the efforts of the staff of the Kentucky State Medical Association in making this such a productive year. However, it is apparent that additional money and staff time are needed if the Kentucky State Medical Association's disaster plans for the Commonwealth are to be effective. There should also be a cooperative balance between the efforts of various governmental and private agencies and the medical profession in disaster preparedness. Adequate funds should be made available by the governmental agencies. The responsibility lies with the Kentucky State Medical Association to do whatever it can to foster preparedness for the frequent natural disasters which occur. Preparations for naturally occurring disasters (plane accidents, storms, fires, etc.) should have primary consideration. It seems obvious that if the medical profession does not take the lead in this problem, that the government will.

Listed below are some of the items which received attention by the committee. They are not listed in order of importance:

(1) The name of the committee was changed to correspond more closely to the AMA's Committee on Disaster Medical Care.

(2) The purpose and objectives of the committee were written and submitted.

(3) The membership of the committee has been changed and increased. Guests from various governmental and private agencies concerned with medical care have visited the committee meetings.

(3a) We are particularly concerned with the neglect of the request to the Health Department to supply Emergency Kits to the Flying Physicians. These kits could be bought from surplus for a very small amount of money.

(3b) We have had a very worthwhile relationship with the Medical Education for National Defense representative at the University of Louisville and plans should be made by future committees to participate in the program at that school and in turn for students and health officers to attend the Kentucky State Medical Association's Committee on Disaster Medical Care meetings. Unfortunately, our efforts to establish relationships with the Medical Education for National Defense representative at the University of Kentucky have gone unanswered.

(3c) The check list as written by the American Hospital Association and the American Medical Association for hospitals for disaster plans which was reviewed by this committee, has been approved nationally and is now available for distribution. Every doctor across Kentucky should ask his hospital administrator about the disaster plans for his hospital.

(3d) Relationships with the Kentucky Hospital Association Disaster Planning Committee have continued. Future committees should determine the extent of inventories of Hospital supplies and equipment which are practical to maintain.

(4) The Civil Defense Emergency Self-Help Training Program has been conducted and the hospital has been demonstrated in 10 counties. Additionally, the hospital will be demonstrated at the KSMA Annual Meeting for 1964.

(5) Thirty three of the Civil Defense Emergency Hospitals are now assigned to Kentucky. A chore of future committees might be to assist the local communities in arranging for staff coverage and in the development of a community disaster plan to incorporate a Civil Defense Emergency Hospital.

(6) The Medical Self-Help Training Program has continued and at the present time 5,020 people have completed the course.

(7) A special issue of the Journal of the KSMA devoted to disaster planning has been written and enthusiastically received nationally.

(8) Future committees should seriously consider moving the meeting place across the state. This might have professional influence on that area to develop its own disaster plans.
Additionally, committee meetings using the Telephone Conference System should be considered. Interim Meetings are held in this manner in both Massachusetts and Pennsylvania. In as much as the Association has refused to permit funds for such a telephone conference, the members of the committee would probably be willing to pay the telephone toll involved.

(9) The availability of reserve and retired officers to assist in disaster planning should be explored. Credits toward their retirement could be achieved in this manner.

*(10) The necessity or the lack of it for Good Samaritan Legislation for the Commonwealth should be investigated and determined in the near future.

(11) The KSMA Committee on Disaster Medical Care continues to be represented on the Governor's Task Force for Health although the present administration has indicated no interest in disaster planning to this date.

(12) The basement of the Kentucky State Medical Association Headquarters Building has been examined by this committee and the State Department of Health as a possible shelter. No action was taken because of the possibility of making this area part of the Central Communications Network for Disaster Planning across the state.

(13) Correspondence has been conducted with the Kentucky Public Health Association, Kentucky Hospital Association, and the Rural Health Council in high hopes that matters of disaster planning would be incorporated in their meetings.

(14) The committee has heartily endorsed the concept of the Emergency Identification tag.

(15) The committee urges that a resolution be passed concerning the development of uni-

**Note: This item was referred to Reference Committee #3.*

form highway signs and map markers indicating available hospital Emergency Rooms. With the Development of the inter-state highway system and the continuing increase in trans-continental automobile travel, the importance of nearby emergency medical services is obvious.

Recommendations, Reference Committee No. 4

The Resolution involving uniform highway signs will be reported by another committee. The problem of the Good Samaritan Legislation as noted in paragraph 10, page 6, has been referred to another committee.

Mr. Speaker, Reference Committee No. 4 moves the adoption of the report on Disaster Medical Care as presented. (Motion was seconded and carried.)

Highway Safety Committee, Arthur H. Keeney, M.D., Louisville, Chairman

The activities during the past year of this committee have centered around the basic areas of Medical Aspects of Driver Limitation, a Kentucky-Cornell A.C.I.R. Program, and a new program of conjoint effort with attorneys in Kentucky. Following is a tabulation of specific undertakings of the committee during the past year:

(1) *Kentucky-Cornell Automotive Crash Injury Research Program.* This program was initiated August 1, 1962, and entered its fourth phase on February 1, 1964 during which time the program will be activated for another six-month period in thirteen additional counties. The program to date has involved nearly 500 single-car accidents and over 200 multiple-car accidents in which approximately 1,300 persons have been injured and 50 have been killed. The quality of reporting by Kentucky physicians and Kentucky State Troopers has been excellent. This program is scheduled to continue for the full three years. The chairman of this committee will meet with the Cornell officers in Buffalo, New York, at the Cornell Aeronautical Laboratories, on July 31 and August 1, 1964, at which time Cornell will be host to the American Medical Association Committee on Medical Aspects of Automotive Safety.

(2) *Medical Aspects of Driver Limitation.* Third revision of the "Statement of Position of the Kentucky State Medical Association" was issued by the KSMA Headquarters Office in January, 1964, bringing up to date the activities and thinking in this regard. There have been many requests for the statement of position from other states and interested organizations. The Trustees of the AMA adopted the Kentucky program in November, 1963, and the AMA House of Delegates similarly adopted this program as a prototype to be recommended by the American Medical Association. This program was published in the JAMA, 187:376 (February 1) 1964.

A meeting was held in the office of the Commissioner of Health, December 5, 1963, with the Commissioners of Health and Safety, at which time a television reel was made concerning the initiation of this program and press releases were distributed to Kentucky newspapers.

Former Department of Safety administrative regulations (D1-6, D1-7, D1-8) became effective June 11, 1964, under KRS 186.400.

(3) At the annual KSMA meeting in Lexington, September 24 to 26, 1963, highway safety exhibits were arranged by the committee for the (a) Department of Public Safety, (b) Cornell Automotive Crash Injury Research Program, and (c) The Irving Airchute Company of Lexington. These exhibits all received good attention and forwarded the cause of safety.

(4) In December, 1963, the National Safety Council awarded its 1963 Surgeons Award for Distinguished Service to Safety to Doctor R. Arnold Griswold of this committee for his long contributing aid in the field of automotive safety. This cited Doctor Griswold as "surgeon, teacher, veteran of two world wars, father of the seat belt resolution of the American College of Surgeons."

(5) At the request of the Jefferson County Police Department, a seminar on the handling of injured persons was held December 17, 1963, and was participated in by Louisville members of the committee, instructing all the Jefferson County police force in two shifts.

(6) At a meeting called by the chairman on February 21, 1964, the presidents of the Louisville Bar Association and the Kentucky State Bar Association were requested to join forces with the KSMA in accordance with instructions issued by the committee at the meeting January 30, 1964. Both of these officers expressed complete willingness. The Louisville Bar Association met on March 7, 1964, and passed the following resolution. The Kentucky Bar Association meeting in April, 1964, also passed a similar resolution and created a Vehicular Safety Committee reporting through the Kentucky State Bar Association annually to the American Bar Association. Similarly, the National Association of Claimant's Compensation Attorneys, in national session in February, 1964, established a Committee on Legal Aspects of Automotive Safety and appointed Mr. Theodore Wurmser, of this city, as chairman to coordinate national level works with NACCA and the American Medical Association. Mr. Wurmser is the Sixth District Governor for the NACCA Bar Association.

LOUISVILLE BAR ASSOCIATION

Resolution

March 5, 1964

WHEREAS, many principles to be applied for the reduction of crash injuries in motorcars have been documented for over thirty years, have been in use in aviation practice for fifteen years, and have been presented in various medical publications since 1934; and

WHEREAS, these principles are a part of basic engineering knowledge, and have been brought to the attention of executive personnel in the motorcar industry by medical, engineering, police, safety, and other groups many times; and

WHEREAS, the motorcar industry gave only minimal recognition to these principles and practices in its products for the 1956 model year, even though automobiles are more readily changed than human behavior or highways and traffic laws,

BE IT RESOLVED that the Louisville Bar Association firmly requests the Automobile Manufacturers Association (320 New Center Building, Detroit 2, Michigan) to incorporate as *standard* equipment for all American motorcars those safety devices, structures and modifications which have been clearly recognized for their reduction of injury and deaths on our roads, and further requests the National Automobile Dealers Association (2000 K Street, N.W., Washington 6, D.C.) to pledge the purchase and sales of cars only when fitted with these acknowledged modifications.

BE IT FURTHER RESOLVED that the Louisville Bar Association pledges the continued operation of a Vehicular Safety Committee to review the action of industry chairmen, presidents, and dealers in this regard and report annually through the Kentucky Bar Association to the American Bar Association on the effectiveness of such injury-reducing designs.

On April 21, 1964, the Kentucky Association of Trial Attorneys produced a seminar on "Product Liability" and a panel composed of Doctors Griswold, Keller, and Kenney represented the medical aspects of automotive injuries to this group. This was a successfully attended meeting with good response from the attorneys in this association.

(7) No significant or truly satisfactory accomplish-

ments have yet been realized in the matter of basic vehicular design modifications. It is still the deep conviction of this committee that the automobile should be a relatively safe place in which to have an accident and it is the conviction of this committee that chairmen of the board, vice-presidents in charge of sales and vice-presidents in charge of design of the major automotive manufacturers must be won to this point of view.

(8) The committee wishes particularly to thank the media which have given such splendid coverage to the activities of the committee during the past year, including:

WAVE hour-long question and answer program, November 8, 1963, 8:00-9:00 p.m.

Lemme-do-it column devoted to driver limitation, Louisville Times, March 26, 1964.

Medical World News, February 14, 1964, page 54.

Greensburg Record-Herald, January 24, 1964.

Bulletin of the American Association of Motor Vehicle Administrators, January, 1964, page 78.

Medical Tribune, on frequent occasions.

This committee also wishes to thank Doctor Paul V. Joliet, Chief, Accident Prevention Division, US Public Health Service, for the complimentary recognition of the Kentucky program and for the meeting arranged here in Louisville with his Research Psychologist, Doctor Louise Thompson, June 4, 1964.

The Committee requests:

(1) Approval of the program to date by the Council on Communications and Public Service, with endorsement of continued activities along these lines;
(2) Authority to develop a conjoint Kentucky State Medical Association and Kentucky Bar Association program in automotive safety;
(3) That sincere or thoughtful suggestions on the part of any physician or individual of the commonwealth concerning highway safety be transmitted to this committee for assistance and evaluation. The committee respectfully solicits any comments from the membership and officers of the Association; and
(4) The Kentucky State Medical Association membership to particularly note the forthcoming annual meeting of the American Association for Automotive Medicine to be held at Stouffer's Louisville Inn, October 26-27, 1964; the president of this committee is Doctor William K. Keller, a member of this committee.

Recommendations, Reference Committee No. 4

This committee concurs with the principles submitted by the Louisville Bar Association in March of 1964. All efforts to achieve seat belts of the shoulder and waist variety are necessary.

Mr. Speaker, Reference Committee No. 4 moves the adoption of the Highway Safety Committee as presented. (Motion seconded; carried.)

Committee on Medicine and Religion, William L. Woolfolk, M.D., Owensboro, Chairman

This committee was formed in the summer of 1963 and had its first meeting at the KSMA Building in Louisville during that summer with Mr. Arne Larson of the AMA present. Mr. Larson explained to the committee in detail the purpose of this new AMA Committee. The committee members then decided to have each committee member sponsor a meeting of Medicine and Religion in his respective County Society. The physicians in the surrounding counties were to be invited. A second meeting of this committee was called for October 21, 1963 in Louisville at the time of the Jefferson County Medicine and Religion meeting. Unfortunately, only Doctor Keen of Bowling Green, and Doctor Woolfolk of Owensboro, were present at that meeting with the Reverend Doctor Paul McCleave. Due to the fact that a quorum was not present, no additional business was transacted.

In addition to the Jefferson County meeting in October, 1963, the only other County meeting on Medicine and Religion was held by the Daviess County Medical Society on April 28, 1964.

I have recently had a letter from Doctor Joe Saunders of Lexington, telling me that his society is planning a meeting on Medicine and Religion in the near future. Doctor Saunders also suggested that the committee have a small booth at the KSMA Meeting in September, which would be staffed by members of the committee in order to explain the committee's purpose to any members who are interested.

We are planning another meeting of the committee at the time of the KSMA Meeting in Louisville, and hope to have Mr. Arne Larson present.

Mr. Larson informed me that the North Carolina Medical Society is planning a TV broadcast during the fall on the subject of Medicine and Religion. Mr. Larson expects to explain this phase of the work at the meeting expected to be held during the KSMA Meeting.

It is regrettable that only two county meetings have been held during the past year, but it is to be remembered that many societies have their programs made up a year or more in advance.

Recommendations, Reference Committee No. 4

Mr. Speaker, Reference Committee No. 4 moves the adoption of the report of the Committee on Medicine and Religion as presented. (Motion was seconded and carried.)

Public Health Committee, M. A. Shepherd, M. D., Somerset, Chairman

On March 19, 1964, the committee met with Russell E. Teague, M.D., Commissioner of the State Department of Health, and Mr. Robert G. Cox, in the KSMA Headquarters Office and decided upon certain actions and recommendations.

It was agreed that KSMA should not only continue to promote Immunization Week in Kentucky, but that we should stimulate each county medical society to have an Immunization Committee. The said committee should work with the local board of health to develop a year-round immunization program designed to get all children immunized before one year of age and to maintain boosters for life.

The committee recommended that a letter should go out to all county societies from the President of KSMA depicting the dire need for better reporting of syphilis to the responsible VD investigators.

The committee concluded that KSMA's most effective approach to controlling disease produced by smoking is through providing family physicians with the facts. With this in mind, the committee recommends to the Board of Trustees through the Council on Communications and Public Service that a symposium on "Tobacco and Health" be scheduled for the 1965 Annual Meeting, and further recommends that if approved by the Board, the request be made known to the Council on Scientific Assembly.

COUNCIL ACTION: The Council takes cognizance of the statements presented in this report concerning a symposium for the 1965 Annual Meeting and feels that this should be forwarded to the Scientific Program Committee for their consideration without council action.

Recommendations, Reference Committee No. 4

Mr. Speaker, Reference Committee No. 4 moves the adoption of the report of the Public Health Committee as presented. (Motion was seconded and carried.)

Rural Health Committee, Donald L. Graves, M.D., Frenchburg, Chairman

The main function of this committee is that of assisting and guiding the Kentucky Rural Health Coun-

cil. Since the council promotes a rural health conference annually, we realize the importance of a close working relationship with the members of the various organizations.

The council consists of twenty-five organizations, and promoting the annual conference is a good way to work with the many groups. The conference presents a means of getting better acquainted with each group's membership and permits us to solicit their help in promoting better health conditions of people in rural areas.

Almost yearly the conference's total attendance increases, and we think this is due to the types of programs which are presented. We now strive to get more local talent to appear on the program, and we also attempt to deal more with the local problems where the conference is being held.

Ever since the Rural Health Council has been organized, the chairman has been a medical doctor and usually he is chairman of this committee. We now feel that the group's working relationship is coming of age and we should take advantage of excellent talent from other organizations. Mr. John Koon, Executive Secretary of the Kentucky Farm Bureau, was selected chairman for this year. We feel this change will stimulate further interest in the council members outside of medicine.

Our committee has had two meetings since the last session of the House of Delegates. One was on October 23, 1963 and the second was May 21, 1964. The purpose of the first meeting was to work out the last-minute details of the 1963 conference program. The second meeting was to have the committee brought up to date on plans for the 1964 conference and make suggestion for any improvements.

This year's meeting will be held on October 22 at the University of Kentucky Medical Center. The type of program will be given to "Opportunities in Health Careers." We might say that although KSMA's Committee on Rural Health has been one of the major forces in the annual conference, the attendance of doctors has been very low through the years. All physicians in driving distance of Lexington who possibly can are urged to attend the careers program on October 22.

Mitchel Denham, M.D., and I represented this committee at the National Rural Health Conference held at Columbus, Ohio, on March 6-7, 1964. Nine other Kentuckians attended and all of us agreed that this was a most outstanding meeting. Next year's national conference will be held in Miami, Florida, in March.

I feel this informal last paragraph is indicated. It has occurred to me that the folks in the Headquarters Staff probably don't get many thanks and I'm sure even though they realize we appreciate their indispensable work, and assistance in all the paper work, we sort of expect it of them and take them for granted. So this committee wants to extend our most sincere thanks to them for their day by day duties that make the KSMA work of its committees and councils possible and as successful as they may be.

Recommendations, Reference Committee No. 4

Mr. Speaker, Reference Committee No. 4 moves the adoption of the report of the Rural Health Committee as presented. (Motion seconded; carried.)

School Health Committee, R. E. Davis, M.D., Central City, Chairman

The KSMA School Health Committee has met twice this year, once January 9 and again on April 2. At our first meeting, we discussed the Athletic Injury Prevention Conferences we have held in the past and again offered our services to the Kentucky High School Athletic Association for additional conferences this year and in the future.

We are happy to report that the Board of Trustees approved our committee's request to sponsor an Association of Team Physicians on the Medical Aspects of Sports. This organization is now being formed under the chairmanship of O. B. Murphy, M.D., Lexington. We are also pleased that our recommendation of last year to have a symposium on Athletic Injury Prevention for the 1964 KSMA Annual Meeting was approved and this symposium will be held Thursday afternoon, October 1 at 2:00 p.m. in the Convention Center, Louisville.

The House of Delegates expressed KSMA's interest in physical education for our school system last year when a resolution on this subject was passed. Your School Health Committee is interested in seeing a state-wide physical fitness program initiated in Kentucky Schools and had Mr. Don Bale, Assistant Superintendent of Public Instruction for the Commonwealth of Kentucky, as a guest at our second meeting to discuss this program. We have volunteered our assistance toward seeing such a program becoming a reality.

The chairman wishes to acknowledge the invaluable assistance and cooperation given him by members of the committee this year.

Recommendations, Reference Committee No. 4

Mr. Speaker, Reference Committee No. 4 moves the adoption of the report of the School Health Committee as presented. (Motion seconded; carried.)

Senior Day Committee, Donald Chatham, M.D., Shelbyville, Chairman

The Senior Day Program was presented to the University of Louisville Medical School graduating seniors on March 16, with the program beginning in the Rankin Amphitheater, Louisville General Hospital and the afternoon session at the Medical Arts Building auditorium.

In general, the program went well, and was received with enthusiasm on the part of the students. Their criticism sheets were passed out to the students and received after the program with some helpful suggestions elicited, which will try to be used in forming next year's program.

The evening speaker was Harlan English, M.D., President of the Illinois State Medical Society, who spoke on the subject of "The Practice as I see It." Doctor English was well received by all present and certainly presented a profitable hour's program to us.

The same program was presented to the seniors at the University of Kentucky Medical School, Lexington, on April 14, with much the same response as was gotten from the Louisville group. On this occasion, also, the students offered some helpful suggestions for next year's program. Herbert Sloan, M.D., was the feature speaker at the University of Kentucky evening program. Doctor Sloan is associated with the University of Michigan School of Medicine.

Both of these Senior Day Programs were gotten off to an excellent start with a speech presented by Doctor George Archer, President of KSMA, who brought a very enlightening and informative paper on his experiences as President of KSMA. It would be worthwhile if all KSMA members could hear Doctor Archer's talk.

Recommendations, Reference Committee No. 4

Mr. Speaker, Reference Committee No. 4 moves the adoption of the report of the Senior Day Committee as presented. (Motion seconded; carried.)

Advisory Committee to the Woman's Auxiliary, J. Andrew Bowen, M.D., Louisville, Chairman

Your Advisory Committee to the Woman's Auxiliary has had no requests for advice and naturally has not voluntarily offered any advice.

Since there has been no business to be discussed, no meetings have been held.

Recommendations, Reference Committee No. 4

Mr. Speaker, Reference Committee No. 4 moves the adoption of the report of the Advisory to the Woman's Auxiliary Committee as presented. (Motion was seconded and carried.)

As chairman, I would like to express my appreciation to all of those who served on the Council and to commend the committees that have served under the Council for their work during the Associational year.

The Council on Communications and Public Service is charged with the responsibility of supervising and directing all Association activities in the field of Public Relations and Services.

COUNCIL ON COMMUNICATIONS AND PUBLIC SERVICE
Donald Chatham, M.D., Shelbyville
R. E. Davis, M.D., Central City
Donald L. Graves, M.D., Frenchburg
Arthur H. Keeney, M.D., Louisville
William T. Rumage, Jr., M.D., Louisville
Robert S. Tillett, M.D., Louisville
N. Lewis Bosworth, M.D., Lexington, Chairman

Recommendations, Reference Committee No. 4

Mr. Speaker, Reference Committee No. 4 moves the adoption of the entire report of the Council on Communications and Public Service, including Board Action of page 17. (Motion was seconded and carried.)

Report of the Council on Allied Professions and Related Groups

PREFACE

Procedures for reports of councils and standing committees of KSMA to the House of Delegates are provided for under Chapter VII, Section 4 of the Bylaws, which reads in part:

". . . . Each standing committee and council shall report annually at least six weeks prior to the Annual Meeting, to the House of Delegates via the Board of Trustees, respecting its activities during the year last past. These reports shall be transmitted without alteration or amendment to the House of Delegates by the Board of Trustees at the Annual Meeting, with such comments or recommendations as the Board cares to make . . . ."

The material in this report of the Council on Allied Professions and Related Groups is presented in the following order:

1. *Actions and recommendations by the Council which it undertook on its own initiative.*
2. *Reports of the committees of this Council with the Council recommendations following each committee report.*
3. *Recommendations by the KSMA Board of Trustees on the overall contents at the conclusion of the report.*

* * * * *

The Council on Allied Professions and Related Groups met once during the Associational year on July 9. Members of the Council approved a statement of duties for each of the committees serving under the council for consideration by the Board of Trustees at their August 6 meeting for inclusion in KSMA policy.

The Council then discussed the activities of its committees and reviewed their final reports. The committees serving under the Council are: Dental-Nurse-Pharmacy Committee, Physical Medicine and Rehabilitation Committee, Infant and Maternal Mortality Committee, Tuberculosis Committee, Blood Banks Committee, and Industrial Medicine Committee.

The following are the final reports of these committees:

Dental-Nurse-Pharmacy Committee, Melvin J. Weber, M.D., Ludlow, Chairman

The committee held one meeting during the past Associational year and all but one member was present. As a result of this session, the following recommendations are made to the House of Delegates:

Liaison with the Pharmaceutical Association

Representatives of both the Kentucky Pharmaceutical Association and KSMA attended the National Congress on Medicine and Pharmacy sponsored by the AMA. Following this congress, the Association received a letter from the President of the pharmaceutical association suggesting that committees from these organizations meet to consider our mutual problems and urged that a voluntary inter-professional code of conduct be formulated and adopted.

Your committee after considering this matter very carefully, asks the House of Delegates for the authorization to meet with the Pharmaceutical Association for the purpose of studying our joint problems and the consideration of the establishment of a voluntary inter-professional code of conduct.

As a means of helping orient future physicians on the matter of working with the pharmacists to better serve the patient, your committee recommends that a pharmacist be placed on the Senior Day Program for both schools in future years, starting with 1965.

Your committee gave careful consideration to the matter of physicians becoming involved in financial affairs of the pharmaceutical industry. It recommends that the KSMA House of Delegates endorse and support the position taken by the AMA House of Delegates as reported in the June 22, 1964 issue of the AMA News:

The House of Delegates statement provided in part:

"Pharmacies—It cannot be considered unethical for a physician to own or operate a pharmacy provided there is no exploitation of his patient.

"Drug Repackaging Companies—It is unthical for a physician to have a financial interest in a drug repacking company.

"Pharmaceutical Companies—It is unethical for a physician to own stock in a pharmaceutical company which he can control or does control while actively engaged in the practice of medicine."

The AMA Judicial Council last November further said, "The term 'repackaging company' as used by the Judicial Council and approved by the House of Delegates refers to a drug company which markets under its own label or trade names drug products manufactured by others with the objective that physicians having a financial interest in the drug company will prescribe its drugs to the patient."

The committee gave much consideration to the way in which the KSMA might work with the members of the nursing profession for the purpose of improving patient care. It reviewed the bill introduced into the 1964 Kentucky General Assembly. Your committee recommends that the House of Delegates authorize the Board of Trustees, as soon after the Annual Meeting as is convenient to be done, to explore with the Kentucky State Association of Registered Nurses and the Kentucky Hospital Association the possibility of making a study leading to the introduction of legislation designed to up-grade and improve the Nurse Practice Act in Kentucky.

COUNCIL ACTION: It is recommended that the report of the Dental-Nurse-Pharmacy Committee be accepted as presented with the exception that the words "Board of Trustees" be replaced by "Council on Legislative Activities" in the last paragraph of the report. The Council further recommends that liaison also be implemented in regard to any legislation which the pharmacists may introduce at the next session of the legislature. This should be well in advance of the next session of the Kentucky State Legislature.

Recommendations, Reference Committee No. 4

Paragraphs 5 and 6 on page 3 have been referred to another committee.

Mr. Speaker, Reference Committee No. 4 moves the adoption of the report of the Dental-Nurse-Pharmacy Committee as presented. (Motion seconded; carried.)

Physical Medicine and Rehabilitation, William K. Massie, M.D., Lexington, Chairman.

Rehabilitation is designed to fit a patient for employment within his capability in the shortest possible time. Following an illness or injury, each patient has a dual impairment: a) a specific impairment to the affected part; b) temporary general decrease in work tolerance resulting from inactivity. The doctor's attention is almost wholly concerned with treating the specific impairment. When, however, the general work tolerance is impaired severely, the patient will not meet the requirements of full employment in acceptable time without supervised rehabilitation. Facilities for providing this service in Kentucky are too few, too expensive, and for the most part, offered on an in-patient basis. More important, however. these inadequate facilities are not overworked. We can only conclude that all concerned, patient, doctor, and compensation carrier, are in general not cognizant of the tremendous waste in man hours of work resulting from the presently accepted method of self-rehabilitation. Medical rehabilitation discontinued before re-employment swells the lists of those placed permanently on welfare, or given social security prematurely for medical disability.

The committee, on considering this problem, was immediately impressed with the many ramifications. It seems obvious that rehabilitation must terminate in re-employement to justify its expense. A patient not returnable to his original work status must be re-trained, and if re-trained, must frequently be re-located to obtain employment. Hence, all these factors must function as a unit. This assumes, however, that all patients are motivated to work at their optimum physical capacity. This is incorrect. Barriers to re-employment are less medical than psychological. The more that is done for the patient, the less he will do for himself.

Recent economic trends in legislation have been toward giving the disabled more economic security by providing monetary relief to which he is entitled by virtue of citizenship alone. No work is demanded on the part of the patient; in fact, if he should work for hire, he is automatically disqualified for supplementary relief. The premium placed on disability, therefore, is obvious, and could eventually destroy the last vestige of motivation.

This committee rapidly concluded that any efforts to increase the facilities and the demand for rehabilitation in the Commonwealth must be multi-directional and sustained sufficiently long to obtain the objective. Since our objectives might coincide with those of other committees, we will outline them briefly so that the Allied Council might better coordinate our efforts.

1. *Disseminate to all KSMA members available facilities within the state* for rehabilitation and the expected per diem cost. Provide a simple directory to each physician to allow him to properly direct his patient to available facilities in re-training, re-employment and re-location. This might be done in an article in our Journal and also outline the information on a patient which might be reasonably expected in a report from such a Center. This would aid the physician in determining the impairment rating and the probable work tolerance.

2. *Inform insurance companies at their annual meetings of the financial advantages of quickly and routinely rehabilitating each patient* requiring such supervision, rather than delegating this to untrained relatives and friends. They must be convinced: a) that the expense of rehabilitation would be offset by the decreased number of weekly payments required before the patient returns to work; b) that impairment ratings would be more accurate after prolonged observation of the patient in working conditions, yet the elimination of any temporary impairment before the rating would probably reduce the final permanent rating.

3. *Meet with state officials of rehabilitation, re-training, re-employment, re-location, and welfare* to formulate a plan of concerted action for each patient, designed to terminate in re-employment. It is here that performance and job matching must be considered. In this computer era, all aspects of patient performance could be tabulated at completion of a course in rehabilitation by the rehabilitation department. Likewise, groups of employers could tabulate requirements for many types of jobs in the same terms. By such electronic matching, the patient with specific limitations might be offered several alternative job openings.

4. *Investigate the possibilities of motivating the disabled.*

A. *Measures to enhance motivation.*

(1) Disability evaluations for compensation patients vary widely between examining physicians. This produces several undesirable features. Physicians become known either as "insurance" or "plaintiff" doctors. It has become a common practice to sum the varying disability ratings and divide in half. This stimulates the patient to seek legal aid routinely, thus putting an undue burden on the courts and unjust expense on a patient who needs compensation badly. A committee could be appointed to investigate a standard which all physicians could follow to render impairment ratings based on purely clinical findings. A professional disability board could then use these physician impairment ratings to correlate the many variables, such as age, education, type of job, socio-economic status, etc., to render a true disability rating.

(2) On the job rehabilitation has been practically eliminated by both the employer and the union. The work tolerance of a long disabled patient can be partially raised at a rehabilitation center. To bring this work tolerance up to the level of heavy labor in such a center is expensive and often impossible. If such a patient, not able or job-situated to return to unrestricted labor, does return to light work under a temporary partial disability status, receiving dual compensation from both the employer and the insurance carrier, he might be returned more rapidly to full activity. This, though, incorporated in the present Workmen's Compensation Law (342.100) is rarely practiced, because of opposition by the employer, insurance carrier, and union.

(3) The patient under some conditions can manipulate welfare to obtain as much compensation for unemployment as he could by working full-time. Often he exceeds full-time pay during the slow season. Would not work relief, substituted for this welfare, discourage this practice? Currently in 9 counties, work relief combined with a daily period of retraining is practiced on a trial basis. The results to date are most encouraging.

B. *Measures now in force which effectively stultify motivation:*

(1) The partially disabled patient may be unable to compete for a full-time job. If he accepts welfare, he must not work. Also a patient on social security below the age of 70 must either forego work or social security payments.

(2) A patient with an impairment amenable to medical treatment may refuse such treatment, accepting an impairment which makes him unfit for labor, but does not disqualify him for wel-

fare. Likewise, a patient unable to obtain suitable employment in his location may refuse employment offered him at a distance, but he remains eligible for welfare.

The above problems are all pertinent to rehabilitation. In fact, rehabilitation cannot be considered apart from them. As a Rehabilitation Committee, we are considering each of them in sub-groups. Since our objectives have been only formulated, and are yet unaccomplished, we as a group would like to participate in next year's Rehabilitation Committee. We feel, however, that additional members would be most desirable, so that the many sub-groups could be composed of physicians so dissatisfied with the status quo that they will give time and thought to rectifying it.

For the first time in many years, the federal government made available $90,000 more than would be matched by state funds on a 3:1 basis.

MEASURES FOR SPECIFIC ACTION BY KENTUCKY STATE MEDICAL ASSOCIATION

1. Appoint a disability committee to investigate and propose a standard for impairment ratings.
2. Request the Journal to prepare a series of articles designed to inform the physicians of a) current rehabilitation facilities, costs, and services; b) agencies available for re-training, re-locating, and re-employment of partially disabled patients currently swelling the lists of the Welfare agencies.
3. Support the recent effort of the Commission on Education to substitute work relief plus retraining for Welfare.
4. Publicize the little used section of the Workmen's Compensation Law 342.100 (on the job rehabilition) as an adjunct to formal rehabilitation.
5. Request state government to match all available federal funds for rehabilitation.

COUNCIL ACTION: It is recommended that the report of the Physical Medicine and Rehabilitation Committee be accepted as presented. The Council requests that the chairman of this committee submit a list of nominees to the Board of Trustees for membership on the Committee on Disability which is recommended in this report.

Recommendations, Reference Committee No. 4

There appears to be very much to gain from the formation of a Disability Committee to investigate and propose standards for impairment rating.

Mr. Speaker, Reference Committee No. 4 moves the adoption and implementation of the report of the Physical Medicine and Rehabilitation Committee as presented. (Motion was seconded and carried.)

Infant and maternal mortality committee, Barton L. Ramsey, Jr., M.D., Somerset chairman.

The Maternal Mortality Committee has met quarterly during the past year. The subcommittee on infant mortality met at one time during the last year. Pediatricians on this committee want to select their chairman with the approval of KSMA and move forward with the study of infant mortality in Kentucky. The members of the Infant Mortality Committee helped start a postgraduate program in June, 1964, at the University Hospital in Lexington, Kentucky. This program is for nurses giving newborn care at any hospital in Kentucky. They have had their first class.

The present Committee on Infant and Maternal Mortality has found it impossible to cover both functions and has in effect functioned as two separate committees from the beginning. In accordance with the recommendations of the American Medical Association, we recommend that the Infant and Maternal Mortality Committee be organized into two separate committees: A Maternal Mortality Study Committee and a Perinatal Mortality and Morbidity Study Committee.

The annual report of the Kentucky Mortality Committee is presented for your information. You will note that this information is approximately two years behind date primarily for legal reasons.

We find the State Health Department and the KSMA staff are very energetic workers.

Recommendations, Reference Committee No. 4

Mr. Speaker, Reference Committee No. 4 moves the adoption of the report of the Committee on Infant and Maternal Mortality as presented. (Motion was seconded and carried.)

**Note: Statistical reports covering maternal deaths in Kentucky for the years 1960, 1961 and 1962 are available at KMA Headquarters on request.*

INDUSTRIAL MEDICINE COMMITTEE, GRADIE ROWNTREE, M.D., LOUISVILLE, CHAIRMAN.

The KSMA Committee on Industrial Medicine met on Wednesday, June 17 at the KSMA Headquarters Office.

It was taken by common consent that the committee approve the following statement consisting of the duties of this committee:

The purpose of this committee shall be to promote higher standards of industrial health, to study and advise the KSMA Board of Trustees on legislation to improve industrial safety and minimize occupational diseases, and to advise and cooperate with industries and companies who request counsel on organizing or re-organizing their company health program.

During a discussion of the committee's duties, the members felt that this included liaison with county medical society industrial health committees, liaison with insurance companies, and liaison with the Kentucky Workmen's Compensation Board. It is also our opinion that we should serve as Industrial Medical Consultants to companies and industries requesting assistance in this field. In the field of legislation, we plan to secure copies of current Kentucky Workmen's Compensation Law and propose additional legislation should we find a need existing. Your committee recommends that the county medical societies should consider organizing committees on Industrial Medicine and we encourage physicians in the Industrial Health field to become members of the Kentucky Industrial Medical Association.

Your Industrial Medicine Committee is planning to meet with representatives of the insurance industry to determine how we can improve the health of our working population and to discuss the relationships in this area existing between insurance carriers and industrial medicine physicians.

The committee also reviewed literature from the AMA which outlined the activities of other medical groups in the occupational health field and will plan to implement any such activities which are felt to be beneficial to Kentucky.

Recommendations, Reference Committee No. 4

Mr. Speaker, Reference Committee No. 4 moves the adoption of the Industrial Medicine report as presented. (Motion seconded and carried.)

Blood Banks Committee, Ellis A. Fuller, M.D., Louisville, Chairman.

This committee has not met in the past year and has not had any specific material referred to it.

COUNCIL ACTION: It is recommended that the report of the Blood Banks Committee be accepted as presented. The Council would like to bring to your attention the following policy statement on Blood Banks submitted by the AMA Board of Trustees and approved by the AMA House of Delegates and recommends that this policy be put into effect in Kentucky.

"In recent years there has been a dramatic growth of blood banking facilities in the United States. The procurement of human blood and

its transfusion to patients are medical procedures which require the direction and supervision of a physician. The ultimate objective of these procedures is the welface of persons who require blood or blood derivatives. The medical profession has primary responsibility for the care and treatment of patients and, therefore, has a paramount interest in evaluating facilities and procedures for blood procurement, storage and use. This responsibility can best be discharged by medical societies at the local level.

"The American Medical Association's Committee on Blood believes that component and constituent medical societies should be informed of proposed and existing blood banking services within the community and should offer guidance to them. In the opinion of the Committee, it is highly essential that the organization of new blood banking programs and the modification of existing ones should have, in the interest of public health and safety, *the approval of the county or district medical society and therefore should be coordinated with existing approved blood banking facilities, that since a blood bank can well be considered a medical facility, the over-all director—the top authority in the blood bank—should be a doctor of medicine.*"

Recommendations, KMA Board of Trustees

This report was reviewed by the Board of Trustees on August 5, 1964.

BOARD ACTION: Approved with the exception of the wording on page 17 of the council action on the Blood Banks Committee which reads—". . . that since a blood bank can well be considered a medical facility, the over-all director—the top authority in the blood bank—should be a doctor of medicine," be changed to eliminate the word "should," and the section of the report referrable to the Tuberculin testing of schools be not approved with the recommendation that this problem be left to the individual counties.

Recommendations, Reference Committee No. 4

Mr. Speaker, Reference Committee No. 4 moves the adoption of the Blood Banks Committee report as presented, including the Board action as listed on page 18 in which the elimination of the word, "should" is important. (The motion was seconded and carried.)

Tuberculosis Committee, J. Ray Bryant, M.D., Louisville, Chairman.

The Tuberculosis Committee met once during this past year on Thursday, April 16 and had as our guest Mr. Thomas Summers of the Kentucky Tuberculosis Association. Mr. Summers discussed with the committee a proposed Tuberculin Testing Program which is planned to be a joint effort of state and local health departments, the State Department of Education, the State Tuberculosis Hospital Commission, the Kentucky State Medical Association, the Kentucky Tuberculosis Association, and the medical schools of the University of Kentucky and the University of Louisville.

The purpose of the program would be to:

A. Eliminate TB from schools;
B. Find heretofore unknown cases of TB by interviewing "contacts" of the students who have positive reactions to the test;
C. Demonstrate the practicability of skin testing; and
D. Emphasize that TB is still a major health problem.

Mr. Summers stated that the cost of the project would be born by the TB Control Division of the State Health Department and possibly some funds will be made available by the Kentucky TB Association.

Your committee recommends that the Kentucky State Medical Association go on record endorsing the Tuberculin Testing Program in Kentucky schools. The following certification of Kentucky schools requirements for Tuberculin Testing Programs is presented for your information.

CERTIFICATION OF KENTUCKY SCHOOLS REQUIREMENTS FOR TUBERCULIN TESTING PROGRAM

Class A Certificate:

(1) 95-100 PERCENT of all the PUPILS MUST BE TUBERCULIN TESTED unless known to be reactors to tuberculin. All reactors must be referred to the family physician for follow-up with X-ray and/or other diagnostic work if necessary. Reactors should be reported to local and state health departments. Reactors from previous surveys with small or doubtful reactions (indurations of 5 to 9 m.m. inclusive) should be re-tested.

(2) 100 PERCENT of the SCHOOL PERSONNEL MUST BE TUBERCULIN TESTED unless known to be reactors. All reactors must be X-rayed. If for religious or other legitimate reasons the tuberculin test is refused, the X-ray will be mandatory. Reactors should be reported to local and state health departments. School personnel includes administrators, teachers, janitors, bus drivers, cooks, clerical help, and so forth, plus all part-time employees.

(3) All persons whose X-rays show shadows, which might be caused by tuberculosis, must be referred to their family physician for further study. All results of testing and X-rays should be reported to the family physician in order to stimulate search for the source of infection. If there is no family physician, follow-up may be carried on by local chest clinics, out-patient services of the tuberculosis hospitals, public health departments, or welfare departments.

(4) An educational program must be conducted prior to a tuberculin testing program.

(5) all reactors with indurations of 5 to 9 m.m. should be re-tested within 60 days. All reactors of 10 m.m and over should be X-rayed within 60 days. Special attention should be given youngsters at the beginning and during puberty.

(6) If a pupil or member of the school personnel has received the tuberculin test or chest X-ray shortly before the survey is conducted, a report of such test or X-ray from an accredited source will be accepted and counted in the percentage checked.

(7) The INTRADERMAL TEST IS PREFERRED, although other methods may be employed in accordance to the skill of the professional personnel performing the test. Intermediate strength of PPD is recommended for use. The patch test is not acceptable for school certification.

(8) Annual FOLLOW-UP of the FAMILY MEMBERS and other CLOSE CONTACTS of the reactors is urged. It is especially important among the contacts of children in lower grades, although the contacts of all converters should be carefully screened.

(9) A histoplasmosis skin test be given at the same time the tuberculin test is given, if feasible, in which case a statement denoting that both tests were given will be included in the certificate.

Class B Certificate:

Requirements are exactly the same as for Class A, except that only 85 to 95 percent of the pupils must be tuberculin tested.

COUNCIL ACTION: It is recommended that the report of the TB Committee be accepted as presented with the provision that the Kentucky Tuberculosis Association go to the local medical society for approval before instituting this program in the schools. This reverses the recommendation stated in the original presentation wherein the school initiates the action of securing local medical society approval. If in the state of Kentucky in the near future, there is an appreciable increase in the incidence of Tuberculosis,

the Council recommends that legislation be initiated to require TB testing in school children similar to the Immunization Law now in effect.

Recommendations, Reference Committee No. 4

Mr. Speaker, Reference Committee No. 4 agrees with the Board action as listed on Page 18 in which it states that Tuberculin Testing of students be not approved, but this problem should be left to the individual County Society. Much discussion was necessary for this Committee report. The Tuberculin Skin Testing is commendable, but numerous problems are involved, including financial problems, treatment of those who are found to be positive and the principle that it is difficult for many county societies to carry out a program approved by the State. A Histoplasmosis Skin Test would be very useful in Kentucky. Further study of this problem is recommended by the Tuberculosis Committee. Mr. Speaker, Reference Committee No. 4 moves the adoption of the Report of the Tuberculosis Committee as amended by the Council and endorsed by the Board of Trustees.

After discussion, Richard E. Mardis, M.D., of Jefferson County, offered the following substitute motion which was seconded: The report of the Tuberculosis Committee be approved with the exception that the approval of the local county societies be obtained before any program is put into effect in that county. The substitute motion was passed by the House of Delegates.

As chairman of the Council on Allied Professions and Related Groups, I would like to express my appreciation to the members of the Council and to the committee members who served under the Council.

COUNCIL ON ALLIED PROFESSIONS AND RELATED GROUPS
J. Ray Bryant, M.D., Louisville
Ellis A. Fuller, M.D., Louisville
William K. Massie, M.D., Lexington
Gradie R. Rowntree, M.D., Louisville
Melvin J. Weber, M.D., Ludlow
W. Donald Janney, M.D., Covington, Chairman

Recommendations, Reference Committee No. 4

In the view of the subjects presented to our Committee, it appeared that occasionally there was overlapping of the same functions which may be organized to reduce the number of total committees. Specifically, the Industrial Medicine and Physical Rehabilitation Committees have similar problems and may be combined.

Mr. Speaker, Reference Committee No. 4 moves the adoption of the report on the Council on Allied Professions and Related Groups as a whole as amended. (Motion seconded; carried.)

The Chairman of Reference Committee No. 4 wishes to thank all the members of the Committee and the secretary, Miss Linda Powell, for their splendid cooperation.

REFERENCE COMMITTEE NO. 4
Paul H. Klingenberg, M.D., Covington, Chairman
William E. Becknell, M.D., Manchester
Andrew M. Moore, M.D., Lexington
Paul J. Sides, M.D., Lancaster
B. H. Warren, M.D., Owensboro

REFERENCE COMMITTEE NO. 5 †

David W. Kinnaird, M.D., Chairman
Reports on Medical Service

† *See note (†) bottom of column one, page 962.*

The following reports and resolutions were considered by this reference committee:
14. Report of the Council on Medical Services
23. Report of the Board of Directors, Kentucky Physicians' Mutual, Inc.
24. Report of the Board of Trustees, Rural Kentucky Medical Scholarship Fund
32. Report of the Advisory Committee to Selective Service
27. Report of the Technical Advisory Committee on Indigent Medical Care
34. Report of the Representative, Kentucky Mental Health Planning Commission
Resolution A
Resolution F

Report of the Council on Medical Services

PREFACE

Procedures for reports of councils and standing committees of KSMA to the House of Delegates are provided for under Chapter VII, Section 4 of the By-laws, which reads in part:

". . . Each standing committee and council shall report annually, at least six weeks prior to the Annual Meeting, to the House of Delegates via the Board of Trustees respecting its activities during the year last past. These reports shall be transmitted without alteration or amendment to the House of Delegates by the Board of Trustees at the Annual Meeting, with such comments or recommendations as the Board cares to make. . ."

The material in this report of the Council on Medical Services is presented in the following order:

1. *Actions and recommendations by the Council which it undertook on its own initiative.*
2. *Reports of the committees of this Council with the Council recommendations following each committee report.*
3. *Recommendations by the KSMA Board of Trustees on the overall contents at the conclusion of the report.*

* * * *

The Council on Medical Services has met twice during this year, March 5 and July 2. A third meeting is scheduled for July 30 and a report of this meeting will be added as an addendum to this final report.

At its first meeting, the Council members reviewed Resolution J on the Kentucky Penal and Parole Systems Report approved by the 1963 KSMA House of Delegates. This resolution dealt with recommending the adoption of the medical services improvements called for in the report. A copy of the resolution was sent to the Governor and the Commissioner of Corrections and representatives of the Council are planning to meet with the Commissioner to further our assistance in seeing these recommendations adopted. Also at its first meeting, the Council discussed the activities and plans for activities of the various committees serving under the Council and approved a statement of duties of the committees which will become a part of the policy of KSMA. The committees serving under the Council are: Insurance Committee, Medical Discipline Committee, Mental Health Committee, Sub-Committee on Alcoholism, Advisory Commission to Blue Shield, Advisory Committee to Blue Cross, Physicians' Placement and Membership Committee, Federal Medical Services Committee, Medicare Review Committee, and Committee on Aging.

For consideration at its second meeting, the Council had been requested by the Board of Trustees to obtain all available information on the medical programs which are a part of or related to "Appalachia," a special project for comprehensive maternity and infant care to selected high risk women and infants, and other government sponsored programs of medical care.

A special workshop meeting on "Appalachia" was held on May 28 with representatives of this Association, State Department of Health and other interested individuals (It is noted by the Council that there is no Appalachia medical care program in existence as

such at the present time). On July 2, a report of this meeting was presented to the Council members and a detailed discussion on these various health care programs was held. Your Council feels that they still do not have sufficient information to recommend any specific KSMA policy and as mentioned earlier in this report, has called a special meeting of the Council members and invited guests to study further the problems referred to it by the Board.

However, the Council feels that this association should be informed on any and all medical care programs planned for the state of Kentucky and makes the following recommendations:

1. We recommend to the KSMA Board of Trustees that the Committee on Public Health be requested to meet with the Commissioner of Health periodically to review health care programs and that other appropriate KSMA committees meet with the directors of other health agencies in state government health care programs as a means of the association's membership being better informed for cooperative purposes to the programs.

2. We recommend to the KSMA Board of Trustees that they request the Commissioner of Health to keep as well informed as possible with regard to various health programs across the state and transfer that information by way of the Board of Health to the medical profession in general so that the members of the medical profession may be informed through the Journal of KSMA of these programs and activities.

The following reports of the committees serving under the Council are herewith submitted.

Recommendations, Reference Committee No. 5

The Report of the Council on Medical Services summarized the problems relating to the coordination of various health agencies of state government and made recommendations that would permit appropriate KSMA committee liaison with these health agencies as well as encourage the Commissioner of Health to keep the KSMA informed as to various health programs.

Mr. Speaker, I move the adoption and implementation of this section of the report. (Motion was seconded and carried.)

ADDENDUM TO THE REPORT OF THE COUNCIL ON MEDICAL SERVICES

The Council on Medical Services held its third meeting of the year on July 30. This was a special called meeting to discuss various medical care programs being conducted in Kentucky. The Board of Trustees has requested that this Council become knowledgeable of medical care programs which are a part of or related to "Appalachia." Invited guests attending the meeting included C. Fred Blankenship, M.D., University of Louisville School of Medicine, Stephen G. Edelstein, M.D., State Department of Health, Irving Kanner, M.D., Fayette County Medical Society, Andrew M. Moore, M.D., President, Fayette County Medical Society, Douglas E. Scott, M.D., Chairman of the KSMA Board of Trustees, and Russell E. Teague, M.D., State Commissioner of Health.

A general discussion was held on the fragmentation of health services and how this appears to be a problem in that various state agencies conduct similar health programs and cooperation is not of maximum efficiency. These programs come from various state departments such as the Department of Mental Health, the Department of Health, the TB Hospital Commission, the Commission for Handicapped Children, etc. It was taken by common consent that the council recommends to the Board of Trustees that the Board request the proper committee or committees to study the problem of coordinating the various health agencies now existing through the various state departments and that the committee report back with its recommendations to the Board of Trustees.

The Council goes on record as having received a report on a project to study causes of accidents in selected Eastern Kentucky counties and approves this program as being conducted. We recommend that the findings and conclusions be made available to the Kentucky State Medical Association and other interested parties such as industry.

The Council also received a report concerning the activities of a special multi-phase health screening project in 18 Eastern Kentucky counties. The report was presented by Russell Teague, M.D., State Commissioner of Health, and Stephen Edelstein, M.D., who is in charge of the project. The Council recommends that this study continue to be done only with the approval of the county medical society concerned, and that the cases discovered continue to be referred to the private physicians. The Council feels that the existence of poor follow-up care of the health problems that this screening program has uncovered is in large part due to a lack of health education which in turn is a part of inadequate general education for much of this population.

A special project for "Maternal and Infant Care to Selected High-Risk Women and Infants in Fayette County to Prevent Mental Retardation" was considered by the Council on Medical Services. It is evident that the proposal as originally given to the Fayette County group was not acceptable to this group for numerous reasons and a special committee of the county society is in the process of attempting to develop a more acceptable method of dealing with this problem. As a matter of establishing a policy, the Council on Medical Services recommends to the Board of Trustees that the Council approves the policy that physicians should continue to give of their services for the care of the indigent as they have done in the past and in those cases where tax funds are available for payment of physicians' fees and the care of the indigent, physicians should be willing to accept a level of payment below the fees that would normally be charged to their private patients.

At the time this report is written, the Council does not know what action the Fayette County Medical Society will take in regard to adopting a plan for Comprehensive Maternal and Infant Care of Medically Indigent Patients.

Following a general discussion on the subject of Infant and Maternal Care which was presented by the Commissioner of Health, the Council recommends that either a committee for the study of Infant and Maternal Care be created or that these duties be added to a committee now in existence. The Council further recommends, at the request of the Commissioner of Health, that closer liaison be maintained between a committee assigned such duties and the State Department of Health.

The Council also discussed the present status of the Federal Administration's proposed Appalachia Program and has nothing specific to report on this matter at the present time. In reality there are two separate bills, one on Appalachia and an Anti-poverty Bill. There are no known medical implications in the Appalachia Bill; and although there might be some medical implications in the Anti-poverty Bill, no specifics are presently known.

Recommendations, Reference Committee No. 5

The recommendation for a review committee for the study of Infant and Maternal care to be created or assumed by a committee now in existence is felt to be a worthwhile recommendation.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded.) Irving Kanner, M.D. of Fayette County then offered the following amendment, which was seconded: It is the sense of the House of Delegates that it disapprove that part of the addendum to the Report of the Council on Medical Services which reads on page 18 of the report: . . . "and in those cases where tax funds

are available for payment of physicians' fees and the care of the indigent, physicians should be willing to accept a level of payment below the fees that would normally be charged to their private patients".

The vote on the amendment carried.

Insurance Committee, J. A. Bishop, M.D., Louisville, Chairman

The Insurance Committee has not met this year since no matters have been referred to this committee for action. Your chairman has enjoyed working with the Insurance Committee in the past and hopes the committee continues to function as a member of the Council on Medical Services.

Recommendations, Reference Committee No. 5

The Insurance Committee report was reviewed and is recommended for acceptance.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried.)

Mental Health Committee, Frank M. Gaines, M.D., Louisville, Chairman

The Mental Health Committee had a series of four major meetings and a large number of sub-committee meetings primarily to plan the Congress on Mental Health which took place on May 14, 1964 in Louisville, Kentucky. This meeting, attended by 150 participants both physicians and non-physicians, was organized to present the general developments in the mental health field and encouraged physician participation. The Committee is currently making efforts to evaluate the Conference in order to make further plans for next year.

The committee wishes to thank the Board of Trustees for their financial and moral backing in its activities during the year.

Recommendations, Reference Committee No. 5

The report of the activities of the Mental Health Committee and the promotion of the successful Congress on Mental Health has been reviewed. Its acceptance is recommended by this reference committee.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Sub-Committee on Alcoholism, John C. Keeley, M.D., Owensboro, Chairman

The Kentucky State Medical Association's Sub-Committee on Alcoholism met once this year on June 11. This was an organizational meeting in that it is our Association's first formal committee on Alcoholism and this was our first meeting. This is a subcommittee of the Mental Health Committee and serves under the Council on Medical Services.

At our meeting, we reviewed the committee's duties as approved by the council and an Eighteen Point Program on Alcoholism published by the AMA Committee on Alcoholism.

It was taken by common consent that we should limit ourselves to collecting and evaluating information, serve as a clearing house, and furnish information to those seeking it on request. It was felt that our first move should be to find out what the state's problem is and what current resources we have available.

In addition to evaluating the alcoholism problem in Kentucky, we will also review the accomplishments by other states in this field.

I would like to take this opportunity to thank the other members of this committee for their participation this past year.

Recommendations, Reference Committee No. 5

The Subcommittee on Alcoholism has begun an exhaustive study of this problem. This reference committee recommends the acceptance of this study by the House of Delegates.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Advisory Commission to Blue Shield, W. Vinson Pierce, M.D., Covington, Chairman

The KSMA Advisory Commission to Blue Shield met at the KSMA Headquarters Office on April 30, 1964. This was the only meeting held by the Commission during the year.

Part of the meeting was devoted to a resume of the recommendations which have been made to the Kentucky Blue Shield Plan (Kentucky Physicians' Mutual, Inc.) in recent years, and to the actions taken by the Blue Shield Plan in regard to implementing these recommendations. It was pointed out that in every instance thus far, the recommendations of the Advisory Commission have been accepted by the Board of Directors of Kentucky Physicians' Mutual, Inc., and implemented by the Plan.

A report was made to the Advisory Commission by the staff of Kentucky Physicians' Mutual concerning enrollment and activities of the Plan. The continuing growth of the plan in enrollment and in extent of coverage was noted; and it was especially gratifying to note that more and more of our elderly people are continuing their coverage as they retire from groups which are covered by Blue Shield.

Three recent actions of the House of Delegates of the KSMA were referred to the Advisory Commission to Blue Shield for consideration and recommendations.

One of these was Resolution F, introduced by the Campbell-Kenton County Medical Society in the House of Delegates last September, and passed by the House. This Resolution read: "Resolved, that the KSMA recommends to the Blue Plans that any and all policies issued make a clear distinction between hospital and physician services, with Blue Shield paying the physician services."

Members of the Blue Shield staff pointed out that this is being accomplished already; the only area for misunderstanding being that this is not clearly printed on certificates now being issued.

The Advisory Commission recommended to Blue Shield that on new certificates to be issued, the distinction regarding services be more clearly defined.

In regard to the Harlan County Resolution concerning the payment of physiatrists for services rendered in hospitals, it was stated that this is being done routinely by Kentucky Blue Cross-Blue Shield.

In compliance with the recommendation made by Doctor Dave Cox in his Presidential Report, and accepted by the House of Delegates, the Advisory Commission voted to recommend to the Board of Directors of Kentucky Physicians' Mutual, Inc., that in the future, the term of office of a director shall consist of no more than three consecutive terms of three years each, to become effective at the next election (but not to be retroactive).

The staff of Kentucky Blue Shield-Blue Cross reported to the Commission concerning new electronic equipment which has recently been installed in the Blue Shield-Blue Cross Building. The Advisory Commission requested that the staff of Blue Shield think specifically as to how this new equipment could be utilized to spot weaknesses in the operation of the Plan, and promised the help and support of the commission in trying to improve the areas of weakness.

The Advisory Commission to Blue Shield wishes to express its sincere thanks to the Board of Directors and to the staff of Kentucky Physicians' Mutual, Inc., for their cooperation and for their consideration of the various recommendations made by the Commission in the Past.

To Mr. J. P. Sanford and his staff, the Commission wishes to express its appreciation for the invaluable help rendered in carrying out the work of the Commission.

We also wish to thank the House of Delegates of the KSMA, the Board of Trustees, and the President of the Association for their support and confidence during the past year.

Recommendations, Reference Committee No. 5

The complete report of the Advisory Commission to Blue Shield has been reviewed and this committee has faithfully implemented the recommendations made by the House of Delegates of KSMA. Therefore, the members of this reference committee recommend the acceptance of this report.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried.)

Advisory Committee to Blue Cross, Sam Overstreet, M.D., Louisville, Chairman

Your Advisory Committee to Blue Cross consists of some 17 physicians from across the state. We meet monthly, usually four members at a time, at the Blue Cross-Blue Shield Building in Louisville to review questionable or controversial claims that have been submitted to the Blue Cross by physicians. Primarily, this is an educational procedure since most questionable claims are merely a misunderstanding on the doctor's part. Our entire committee has met once this year.

Recommendations, Reference Committee No. 5

The report of the Advisory Committee to Blue Cross has been reviewed and this reference committee recommends the acceptance of this report.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded and carried.)

Physicians' Placement and Membership Committee, Claude E. Cummins, Jr., M.D., Maysville, Chairman

The Placement and Membership Committee met on June 25, 1964, and five of the seven members were present. Duties of the Committee, as approved by the Council on Medical Services and the Board of Trustees, were read, and members were informed that these duties would become a part of Kentucky State Medical Association's Bylaws under the heading of this Committee.

It was interesting to note that our Association's membership reached an all-time high last year. Active members numbered 2,183 on December 31, 1963. To this we can add 102 emeritus for a grand total of 2,285 members. Membership in AMA on December 31 was 1,988. As of May 31, 1964, we had 37 more KSMA and 32 more AMA members than we had on the same date in 1963.

According to our best estimates, we have about 2,700 physicians in Kentucky. We would like to be more positive about this figure. This Committee in 1963 made a recommendation to the House of Delegates that approval be given for annual registration so we could be more definite as to the number. It was interesting to listen to a tape recording of the 1963 House of Delegates meeting and hear comments made by those who were opposed to annual registration. One opponent said we could get all the information needed from drug detail men. Another said he thought county medical society secretaries provided this information. Although the Commissioner of Public Health said his Department of Licensure could administer a program of annual registration without fee, one physician took the floor and said he renewed his license to practice in California each year. He said the fee had been increased from time to time and now it costs $20 per year.

At our Committee meeting on June 25 we had information showing that California has biennial registration and the fee is $18. We are convinced that county medical societies could provide the number of dues-paying and non-dues-paying members in the counties, but experience has shown that this is not working. Drug detail men are the biggest group requesting the medical directory published by the Division of Licensure. Incidentally, it takes about six months to check the information for the medical directory, which is revised every two years. This could be done in about one month and much more accurately if there were a good system of annual registration. Thiry-five states require physicians to register annually, and another ten require registration biennially.

Other reasons for annual registration are:

1. The Indigent Medical Care Program requires the signature, license number and other information before any reimbursement can be made. On numerous occasions vendor physicians have been delayed payment for their services until such time as this information could be received.
2. Practically all other professions in Kentucky have annual registration of their members.
3. KSMA contracts with the Veterans Administration for Hometown Medical Care and it is not unusual for the Veterans Administration to request information from the Headquarters Office on certain doctors.
4. Seldom a day passes but what the Headquarters Office receives calls from someone asking for such information as the full name of a physician, where and how long has he practiced in the present location, and is he a member of KSMA and AMA.
5. The various specialty organizations frequently contact the office to find the number of specialists and the towns and counties in which they practice.
6. Headquarters Office is often called upon to address envelopes for announcements of doctors. On many occasions, doctors have been critical of the Office when they have a large number of letters returned because they were not given the correct address.
7. The Office gets calls from physicians or lay people from other states asking for leads on physicians who might be practicing in Kentucky.
8. The Alumni Office at U of L depends on the Headquarters Office for much of its information on medical alumni.
9. It is expensive to have letters, journals, and other material returned when sent to the wrong address. It is also embarrassing to the Headquarters Office. It makes it appear that due care has not been exercised in keeping the records current.

Our Committee feels that our Medical Association and the Division of Licensure should not have to depend upon newspaper clippings as their best source of information on doctors entering practice for the first time, changing locations, and for information on those who have died. For the reasons mentioned above and many others, our Committee strongly recommends that our Kentucky State Medical Association House of Delegates authorize the Commissioner of Health to establish a regulation in his Department making it compulsory for all physicians to register annually.

Recommendations, Reference Committee No. 5

The reference committee discussed in detail the portion of the report dealing with annual physician licensure registration, and in spite of some valid objections, it is the recommendation of this committee that this annual physician licensure registration proposal be endorsed by the KSMA House of Delegates and that the Commissioner of Health establish the mechanics of the annual registration as outlined in the report.

After discussion, Martin Wilson, M.D., Warren County, proposed an amendment that the report dealing with annual physician licensure registration in the report of the Council on Medical Service be adopted with the exception of the sentence on page twelve which reads: "For the reasons mentioned above and many others, our Kentucky State Medical Association House of Delegates authorize the Commissioner of Health to establish a regulation in his Department making it compulsory for all physicians to register annually." The motion was seconded and the amendment carried.

Report of Physicians' Placement and Membership Committee (Continued)

We reviewed the Negro situation relative to membership in KMA. Seven counties have Negro physicians and four of this number accept them as members. It is understood that two other counties will take them as members if such requests are made. Negro doctors have hospital staff privileges in six of the counties. Since this subject does not present an acute problem in Kentucky, and in view of the fact that it is brought up as an issue each year at the AMA Annual Meeting, our Committee urges each county medical society having Negro doctors to accept them as members in the county medical society. This, of course, is with the understanding that they have completed training in a class A medical school, finished an approved internship, passed the state medical board examination, and are ethical and eligible in every respect.

The Placement part of our Committee's responsibility has been most effective during the past year. A large number of trained doctors have gotten information through our Placement Service and have located throughout the state. This Service definitely makes for a better distribution of doctors because they learn of locations they might not hear about otherwise. We particularly want to commend the work of those responsible for the Rural Kentucky Medical Scholarship Program for their efforts in placing doctors in needed areas. The 122 Scholarship recipients now practicing in 75 different counties have certainly been a credit to our KMA.

Recommendations, Reference Committee No. 5

The subject of Hospital staff privileges of Negro doctors in our county societies has been well reviewed, and it is our recommendation that each county medical society accept Negro physicians as equal members as proposed by the Physician Placement and Membership Committee.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

In addition, we recommend that the Bylaws be amended to Section 4, Chapter XI be eliminated in so much as this section refers to the issuance of charters to organizations of Negro physicians outside of the county medical societies.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried.)

Mr. Speaker, I move the adoption and implementation of this section of the report as modified. (Motion seconded and carried.)

Federal Medical Services Committee, L. F. Beasley, M.D., Franklin, Chairman

The Federal Medical Services Committee has been in frequent communication with the Federal Government concerning the Federal Services contract (the true medicare program for dependents of active armed forces personnel).

A new contract for 1964-1965 identical with the 1963-1964 contract was signed with the Federal Government. There have been no complaints. In the absence of specific business, no meeting has been held this year.

Recommendations, Reference Committee No. 5

This report was reviewed and is recommended for acceptance.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Medicare Review Committee, Henry Collier, M.D., Louisville, Chairman

The Medicare Review Committee acts on special cases submitted under the true Medicare Program (Medical Care for Dependents of Active Armed Forces Personnel). Normally this committee meets semi-annually with representatives of Blue Cross-Blue Shield and representatives of the Office of Dependents Medical Care, Denver, Colorado.

During the calendar year 1963, the number of claims paid under this program increased while the special cases reported to the committee decreased approximately 34%. There were, during this period, 5,275 claims paid and 97 cases reviewed by members of the committee for our recommendation.

We have continued our policy of distributing claims among the committee members according to their specialty in order that the claims needing review can be considered by the physician in the proper specialty.

Recommendations, Reference Committee No. 5

The activities of the Medicare Review Committee have been reviewed and this report is recommended for approval.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded and carried.)

Committee on Aging, Earl P. Oliver, M.D., Scottsville, Chairman

The KSMA Committee on Aging met once during the Associational year, on May 12, 1964. The committee members approved a statement outlining the duties of the committee and held a general discussion on the Kerr-Mills Program in Kentucky. The committee feels that there is a need for a provision in the Kerr-Mills Program to cover those recipients who have a protracted illness which requires more than ten days hospitalization.

The chairman had the pleasure of representing KSMA and the Aging Committee at a meeting in Atlanta this year on the Institute on Facilities for Long-Term Illnesses. A report on this meeting has been submitted to the chairman of the Council on Medical Services.

The Committee also discussed this year the problem of classifying and upgrading nursing homes. The committee recommends to the KSMA Board of Trustees through the Council on Medical Services that the KSMA Journal carry requirements for accreditation of nursing homes and applications for approval procedures. It was further recommended that each county society secretary and each hospital chief of staff be sent the following:

(1) Advice on categories of nursing homes;
(2) Where to apply for accreditation; and
(3) That the cost for accreditation visit is $75.00 plus $1.00 per bed.

The KSMA Committee on Aging recommends to the House of Delegates through the Council on Medical Services and the Board of Trustees that:

(a) KSMA continue to give its full support to the AMA's Eight Point Program for the Aging.
(b) The Physicians of Kentucky continue to encourage and assist the Senior Citizens in preventing illnesses, preserving their health, and remaining a part of the main stream of life by remaining useful and participating in the family group and all walks of life as long as possible.
(c) The KSMA members discourage increased federal governmental control over the lives of our older citizens and citizens of all age groups.
(d) The KSMA encourage the upgrading and improvement of the nursing home facilities in Kentucky, and strive to have a high-grade level of nursing care and medical care rendered in these facilities; and further that the KSMA members stimulate the building of the necessary number of acceptable nursing home facilities in Kentucky.
(e) The KSMA go on record endorsing the accreditation of nursing homes by the National Council for the Accreditation of Nursing Homes, but submit a request to the Council that the standards not be made unattainable because of a lack of qualified personnel to staff the nursing homes.

COUNCIL ACTION: It is recommended that the report of the Aging Committee be accepted as presented with one exception. The Council recommends that the words "on request" be added to the last sentence of the third paragraph making it read: "It was further recommended that each county society secretary and each hospital chief of staff be sent on request the following:". In reference to the first paragraph, it is the understanding of the members of this Council that some provision is made for such patients in dire need.

The chairman of the Council on Medical Services would like to express his sincere appreciation to the committee chairmen, the committee members, and to those who have served on the Council on Medical Services.

COUNCIL ON MEDICAL SERVICES
John A. Bishop, M.D., Jeffersontown
Frank M. Gaines, M.D., Louisville
Earl P. Oliver, M.D., Scottsville
Sam A. Overstreet, M.D., Louisville
Robert E. Pennington, M.D., London
Claude C. Waldrop, M.D., Williamstown
W. Vinson Pierce, M.D., Covington, Chairman

Recommendations, Reference Committee No. 5

The report of the Committee on Aging was found to have many important suggestions for dissemination of information on accreditation of nursing homes. In addition, the committee summarized the interest and efforts of Kentucky physicians to assist the older citizens while at the same time discouraging increased federal government control of these senior members of our society. The plea to the National Council for Accreditation of Nursing Homes not to make the standards for acceptance unobtainable because of certain personnel requirements, was noted and thought to be of importance.

The entire report of the Committee on Aging is recommended for acceptance.

Mr. Speaker, I move the adoption and implementation of this section of the report. (The motion was seconded and carried.)

Report of the Board of Directors, Kentucky Physicians' Mutual, Inc.

The Board of Directors of Kentucky Physicians Mutual, Inc. respectfully presents its annual report to the Kentucky State Medical Association. It reflects the fifteenth year of operation and service to the people of Kentucky.

As of July 31, 1964, 848,469 people were members of the Plan, an increase of 37,808 over the membership one year ago. In addition, 41,396 persons are now also enrolled in our Extended Benefits program and 9,696 persons in the Major Medical coverage. During the 12-month period ending June 30, 1964, $9,257,865.18 was paid to physicians. This is an increase of $908,840.29 over the previous 12-month period. Calendar year 1964 payments to physicians will approximate 10 million dollars.

The cost of operation for the year ending June 30, 1964 was 10.6% of income. We continue to rank favorably with other Blue Shield Plans with respect to operating cost in that only 9 of the 71 Blue Shield Plans operated at less administrative cost per member than the Kentucky Plan.

During the year the new group rates based on experience have been instituted, and the downward trend in financial experience has been corrected.

The standard coverages are now no longer offered, and all new subscribers are being enrolled on the more equitable "C" and "D" schedules. Also, an all-out effort is being made to get the old standard subscribers to switch to the better coverage.

Blue Shield, being a mutual insurance company, continued to be harassed by municipalities seeking to collect premium taxes. A number of settlements were made. However, through the leadership of the legislative council of the State Medical Association we were able to support passage of legislation when passed exempting hospital, dental, medical, and/or surgical, domestic, mutual insurers from these levies.

During the year the Kentucky State Medical Association formed an Insurance Review Board, which will be of great assistance in fostering the voluntary prepayment system.

At its January 27, 1964 meeting your Board voted to cooperate with any County Society that desired to institute a pay-all plan. First county to take advantage of this is Perry County.

In closing I want to express my appreciation to all members of the profession who, by their cooperation, have made another successful year for the Plan. I would particularly like to thank those who were so diligent in obtaining the worthwhile legislation vital to our continued progress. My deep appreciation is also expressed to members of the Board, fellow officers and staff for making this another successful year.

William H. Cartmell, M.D.
President

Addendum to the Report of the Kentucky Physicians' Mutual, Inc.

It will be recalled by you that David Cox, M.D., in his Presidential Report to the House of Delegates of the KSMA in 1963, pointed out that members of the Board of Trustees of the KSMA were limited to two three-year terms, and that members of the Board of Trustees of the AMA were limited to three three-year terms. It was Doctor Cox's recommendation that his proposal should not begin to operate until the beginning of 1964, and that all present members of the Board of Directors would be eligible to serve the full three terms of three years each.

This proposal of Doctor Cox was approved by the Reference Committee and adopted by the House of Delegates. It was referred to the Advisory Commission for implementation, and the Advisory Commission in turn voted to recommend that the Board of Directors of KPM adopt this as their policy in the future.

At the meeting of the Board of Directors of KPM, held on September 27, 1964, the Board voted to approve the policy of limiting the terms of its Directors (not to be retroactive) to three terms of three years each; and a special committee was appointed to present this recommendation to the meeting of the members to be held later in this year; since the Directors are elected by the members of KPM at their annual meeting.

It was the feeling of the Board of Directors that this new policy should apply to the physician members of the Board, but not necessarily to the lay members.

Recommendations, Reference Committee No. 5

The report of the Board of Directors, Kentucky Physicians' Mutual, Inc., as well as the addendum to the report has been studied and it is found to be complete and adequately signifies the continuing excellent operation and services to the people of this state. The committee therefore recommends the acceptance of the report.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded and carried.)

Report of the Board of Trustees, Rural Kentucky Medical Scholarship Fund

Our Rural Kentucky Medical Scholarship Fund is observing its eighteenth birthday this year. The revolving fund which started in 1946 was designed to

help medical students financially and in return they would agree to practice in a qualifying rural area of Kentucky twelve months for each loan received.

Founders of the Scholarship Program put on a fund-solicitation campaign when the Program was initiated, and $168,117.45 in contributions were received.

In 1954 Governor Lawrence Weatherby allocated $10,000.00 to the Fund from the Commonwealth for the last biennium of his four-year term. Governor A. B. Chandler followed with $100,000.00 during his four-year term (1956-59). Governor Bert T. Combs budgeted $100,000.00 during his term and, in addition, took $15,000.00 from his emergency fund. This makes a total of $225,000.00 received from the Commonwealth. A grand total of $393,117.45 has been placed in the revolving fund from both private and Commonwealth donations as of July 1, 1964.

Governor Edward (Ned) Breathitt is allocating $60,000.00 for the first biennium of his term, and $30,000.00 of this amount is expected to be available during the latter part of July.

A total of 741 loans have been granted to 258 different students for an average of 2.87 loans per recipient. The average amount of each loan has been $889.40 with a total of $659,046.00 being lent since the revolving fund started.

After checking with The Louisville Trust Company, fiscal agent for the Fund, we find that on June 5, 1964, outstanding notes signed by the recipients amounted to $380,035.93. It is anticipated that money coming in from due notes and from the Commonwealth plus cash on hand will be sufficient to permit us to make 46 loans of $1300.00 each this year for a total of $59,800.00. The Trustees of the Fund favor larger loans to fewer students each year in order that recipients will feel that the Fund is a major source of the income which helped them get through medical school. This will naturally cause them to have more concern and respect for the Program.

Interest collected from recipients as their notes are repaid just about takes care of the Program's administrative cost. When recipients locate in any of the ten most critical counties in need of physicians and loans are cancelled for each twelve months of practice given, this amount comes out of the principal portion of the Fund if there is not a sufficient amount in interest money. Loans will be cancelled for four recipients this year because they are practicing in critical counties.

The Board has its annual meeting in May of each year. At this time first-loan applicants are interviewed and those qualifying are approved for loans. Also, second-, third-, and fourth-loan applicants are approved, but personal interviews for this group are not required. The critical counties are reviewed, and a decision is made on the ten most critical counties for the coming year. Counties on the list for July, 1964 to July, 1965 are Martin, Owsley, Magoffin, Elliott, Leslie, Knott, Wolfe, Breathitt, Powell, and Lee.

The Executive Committee of the Board of Trustees meets annually in August. During this meeting, more time is given to individual requests and problems, and a more comprehensive review is made of the entire program.

A Postgraduate Committee composed of three members meets as need indicates. This Committee approves or disapproves each recipient's request to take a residency. This year the Trustees approved postgraduate training in pediatrics, internal medicine, family practice, general practice, and ophthalmology. These will be added to the original list of pathology, radiology, anesthiology, and ENT. The Postgraduate Committee presently approves one recipient per year to take a residency, and the Committee decides which of the approved specialties presents the greatest need in rural areas.

Of the 258 students previously mentioned who received loans, 18 withdrew or were dropped from medical school, 8 were Negroes, 9 were females, and 9 were non-Kentucky residents. Of the non-residents, 3 were from Tennessee, 2 from Indiana, and 1 each from New York, California, Iowa, and Michigan. Because of so many Kentuckians applying for loans, we quit considering the requests of non-residents in 1960.

The 258 recipients of loans attended medical schools as follows: 182—University of Louisville, 31—University of Kentucky, 12—University of Tennessee, 5—Vanderbilt, 5—St. Louis University, 4—Meharry, 3—Tulane, 2—Duke, 2—Emory, 2—Howard, 2—University of Cincinnati, 2—Bowman Gray, and 1 each from Creighton, Temple, Northwestern, Iowa, Wayne, and George Washington University. During the last four years plus this coming year, 31 different students will have attended University of Kentucky while 29 will have attended University of Louisville.

During the 1964-65 school year 51 Scholarship recipients will be attending medical schools as follows: 22—University of Louisville, 26—University of Kentucky, 1—Meharry, 1—Tulane, and 1—University of Tennessee. Twelve will be interning, and eighteen will be meeting their military obligations.

Eighty-four different Kentucky counties have had Rural Scholarship recipients attend medical schools. By number from counties they are as follows: 32—Jefferson; 12—Fayette; 8—Daviess, Floyd, Pike; 6—Whitley, Letcher, Barren; 5—Bell, Calloway, Fulton; 4—Carter, Christian, Franklin, Hardin, Johnson, Kenton, McCracken, McCreary, Madison, Monroe, Nelson, Scott; 3—Clay, Harlan, Hopkins, Marshall, Mercer, Pulaski, Rowan, Todd, Union, Warren; 2—Adair, Allen, Bourbon, Campbell, Casey, Edmonson, Elliott, Grayson, Hancock, Harrison, Henderson, Leslie, Logan, McLean, Marion, Owsley, Powell, Shelby, Washington; 1—Ballard, Boone, Boyd, Boyle, Breckinridge, Bullitt, Caldwell, Carlisle, Clark, Clinton, Crittenden, Cumberland, Estill, Graves, Green, Hardin, Knox, Laurel, Lawrence, Lincoln, Martin, Menifee, Muhlenberg, Ohio, Pendleton, Perry, Rockcastle, Trimble, Wayne, Webster, Wolfe, and Woodford.

Seventy-five different Kentucky counties are now being served by 122 Scholarship recipients. A number of recipients have fulfilled their financial and moral obligations and have moved to other locations. Locations as to number and counties are as follows: 9—Jefferson; 4 — Greenup, Muhlenberg; 3 — Barren, Breckinridge, Hardin, Hopkins, Madison, Monroe, Simpson, Whitley; 2—Boyle, Bullitt, Calloway, Christian, Daviess, Edmonson, Fleming, Grayson, Harrison, Johnson, Larue, McLean, Marshall, Nelson, Owen, Rowan, Shelby; 1—Adair, Anderson, Bath, Boone, Breathitt, Butler, Caldwell, Carlisle, Carroll, Carter, Clark, Clay, Clinton, Crittenden, Cumberland, Floyd, Franklin, Graves, Hancock, Harlan, Hart, Henderson, Jackson, Jessamine, Knott, Laurel, Lee, Leslie, Livingston, Lyon, McCreary, Mason, Meade, Mercer, Montgomery, Nicholas, Pendleton, Pike, Powell, Rockcastle, Russell, Scott, Todd, Trigg, Union, Warren, and Webster.

Locations not approved for recipients to practice are: counties of Campbell, Daviess, Fayette, Jefferson, Kenton, and McCracken, and towns of Ashland, Bowling Green, Frankfort, Henderson, Hopkinsville, Madisonville, Middlesboro, and Richmond. Negro recipients are not restricted as to location; they can practice in any town in Kentucky.

Every member of the Board of Trustees of the Scholarship Fund would like to take this opportunity to thank Governor Breathitt and the 1964 General Assembly for their interest and support in this worthwhile program. We would also like to express sincere appreciation to Doctor Teague for the many contribu-

tions made by him. Lastly, we would like to thank KSMA Headquarters Staff for administering the Program efficiently and effectively.

RURAL KENTUCKY MEDICAL SCHOLARSHIP FUND
C. C. Howard, M.D., Chairman,
Board of Trustees

Recommendations, Reference Committee No. 5

This continues to be a most satisfactory committee activity and these worthwhile efforts are certainly recommended for approval.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried.)

Report of the Advisory Committee to Selective Service

There have been no formal meetings of the committee this year but problems arising have been solved by personal or telephone conversations as needed.

Our relationship with Kentucky's Selective Service System at Frankfort has been pleasant and complete cooperation and understanding have been accomplished.

The number of cases requiring reference to our committee for special consideration seems to be diminishing, as a better appreciation of the draft regulations become better understood.

ADVISORY COMMITTEE TO SELECTIVE SERVICE
James Archer, M.D., Paintsville
Glenn U. Dorroh, M.D., Lexington
Charles B. Billington, M.D., Paducah
O. B. Coomer, D.D.S., Louisville
Sydney G. Dyer, M.D., LaCenter
F. E. Hull, D.V.M., Lexington
Frank Jordan, D.D.S., Louisville
Lula B. McClain, R.N., Louisville
Sam A. Overstreet, M.D., Louisville
Marcus Randall, D.D.S., Louisville
Russell E. Teague, M.D., Frankfort
L. O. Toomey, M.D., Bowling Green
J. Duffy Hancock, M.D., Louisville, Chairman

Recommendations, Reference Committee No. 5

This report has been reviewed and is recommended for adoption.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Report of the Technical Advisory Committee on Indigent Medical Care

Our Technical Advisory Committee met on April 9, 1964, and all six members were present. This was the only meeting of this Committee since the last session of the House of Delegates. The Indigent Medical Care Program appears to be operating in a reasonably acceptable manner, and there has been no drastic change in the Program for the last few months.

At the Governor's Advisory Council on Indigent Medical Care meeting on February 19, 1964, reported general irregularities by the vendors group were discussed. It was pointed out that seven (7) irregularities have apparently occurred in the field of physician services. They are as follows:

1. Billing for services *not* rendered.
2. Billing for services to hospital inpatients or outpatients under the guise of home and office visits.
3. Steering patients to specific pharmacies by the use of telephoned prescription orders.
4. Billing patient over and above the Program payment.
5. Substitution of drugs after they have been dispensed by the pharmacist.
6. Presigning prescription blanks and giving them to the pharmacist.
7. Physician allowing someone else to use his signature.

The Council asked each vendor group to study these charges and make a statement or give recommendations for correcting them at the next meeting of the Council. Our Committee approved the following statements and recommendations, which were reported to the Council on June 24, 1964.

ITEM 1 and ITEM 2: These are acts of dishonesty, and we obviously do not condone such acts.

ITEM 3: We do not propose to deny the use of telephones as a means of transmitting prescriptions. We do propose, however, that if this means of communicating is used, the patient should be given the right to the choice as to the pharmacist selected.

ITEM 4: Our Committee feels that if this practice is at all widespread, it must be a result of misunderstanding rather than any willful violation of either the spirit or letter of the Program. We suggest that it be made clear to vendor groups that:

(a) The Program is a service contract rather than an indemnity one.
(b) Acceptance of each patient is on a date basis rather than an illness basis.
(c) There is nothing binding any vendor to accept a patient.
(d) Provisions are available for returning monies collected in event patient or relatives wish to pay the vendors regular charge.

ITEM 5: If a physician substitutes drugs for his own gain, he should be severely censored. In the event the physician should find that he had erroneously prescribed, a substitute would be in order, and the patient and the pharmacist should be cognizant of this fact.

ITEM 6: If the physician presigns prescription blanks and gives them to the pharmacist, he is in essence giving the pharmacist the right to practice medicine. Unequivocally, we are opposed to this type of medical practice.

ITEM 7: We see no reason why anyone should sign the forms for physicians in this Program except in incapacitating illness and death.

In addition to giving our views on the irregularities, the Committee made the following recommendations to the Council. Many of them have been made previously. They are:

1. That extended hospitalization for certain serious medical conditions be made possible on the advice of, and request of, the attending physician and the involved hospital, such requests being subject to review by a local review committee when requested.

2. That the existing Federal and State laws and operating regulations be reviewed to determine whether or not catastrophic illnesses which deplete rapidly the reserves of a non-eligible participant would permit the individual to become eligible if this catastrophic illness reduces his income or resources to an eligible level, subject to some method of review which would determine his length of eligibility.

3. While this Committee feels very strongly that service pertaining to the health needs of our people based on need should continue, we are ready, and we are sure we represent the feeling of other technical advisory committees, to assist in advance in planning any expansions.

4. We wish to recommend again that studies be made to determine the feasibility of entering into a contractual arrangement with Blue Cross-Blue Shield or some other competent insurance carrier referable to the programs of MAA and OAA.

5. With reference to drugs, our Committee wishes to call your attention to three things:

(1) There is some dissatisfaction with the price the Program is paying for certain drugs.
(2) There is some dissatisfaction with having a drug list at all.
(3) There is some dissatisfaction with the use of a

prescription form.

On the basis of these, our Committee recommends:

(1) That a review of the drug prices be made, and

(2) That since we understand that certain states have discontinued the use of drug lists and form prescription blanks, we would ask the Council to investigate the experiences of these states, securing from them experience which may enable us to operate our Program more economically and efficiently, and more satisfactorily to both vendor and recipient.

We think the medical care identification cards which will be issued to public assistant recipients on a monthly basis may solve many problems, inasmuch as they will be issued just prior to the month of eligibility. This new identification card system is to become effective September 1, 1964.

It is evident that our Indigent Medical Care Program is here to stay, and our Committee is of the opinion that physicians should make every reasonable effort to cooperate with the Kerr-Mills approach. This will result in a situation which should satisfy a majority of our congressmen and cause them to feel that a King-Anderson type legislation is unnecessary.

KSMA Technical Advisory Committee
to the Medical Assistance Program
George Estill, M.D., Maysville
Paul F. Maddox, M.D., Campton
Carroll H. Robie, Jr., M.D., Louisville
Charles J. Shipp, M.D., Greenville
Claude C. Waldrop, M.D., Williamstown
Clyde C. Sparks, M.D., Chairman, Ashland

Recommendations, Reference Committee No. 5

The report of the Technical Advisory Committee on Indigent Medical Care was of interest to the undersigned and the recommendations for corrections of irregularities that have occurred in the field of physicians' services were noted and thought to adequately express the feelings of the majority of physicians. The additional recommendation by this committee pertaining to extended hospitalization for serious medical conditions and the inclusion of non-eligible participants with catastropic illnesses which deplete their resources, ought to be worthy of consideration by all concerned.

The other recommendations for study for contractual arrangements with Blue Cross and Blue Shield as well as review of the mechanics of drug distribution seemed to be deserving of investigative study and may provide useful information.

Your attention is called to paragraph 3 under item 7, which we believe can be interpreted as recommending that any expansion of this program be based on needs of the indigent patient for which this program was originally instituted.

This entire report is recommended to the House of Delegates to be approved in its entirety.

Mr. Speaker, I move the adoption and implementation of this section of the report. (The motion was seconded.)

In the discussion that followed M. R. Gilliam, M.D., Fayette County, proposed an amendment that the report of the Technical Advisory Committee on Indigent Care be accepted with the recommendation that the appropriate agency of this Association take steps to eliminate payment of physicians fees under the Kerr-Mills program. This amendment was seconded.

W. Donald Janney, M.D., Kenton County, proposed an amendment to the amendment that the Report of the Reference Committee be adopted except that the Board of Trustees be directed to study the possibility of termination of payment of physicians fees. This received a second. After further discussion, Doctor Janney with the consent of his seconder withdrew his amendment to the amendment.

A motion was made that the amendment of Doctor Gilliam's be tabled. This was seconded and the motion carried.

A vote was then taken on the original motion contained in the report of the reference committee and this motion carried.

Report of the KMA Representative, Kentucky Mental Health Planning Commission

Background

The Mental Health Study Act, passed by the Federal Congress in 1955, directed the Joint Commission of Mental Illness & Health to analyze and evaluate the needs and resources of the mentally ill in the United States, and make recommendations for a national mental health program. An extensive study was then made by experts under the sponsorship of 36 organizations, including the American Medical Association, making up the Commission. This was published in 1961 under the title "Action for Mental Health."

In 1962, the Congress appropriated preliminary planning funds to implement President Kennedy's program to improve the facilities for mental illness and retardation. Kentucky's share was $63,000 for each of two years. During this time, the State is expected to develop a comprehensive long-range mental health program.

In 1963, the Congress allocated $329,000,000 to the states under the Mental Retardation Facilities and Community Mental Health Centers Construction Act. The bulk of this money is for the construction of facilities with the Federal Government matching available state and local funds varying from 1/3 to 2/3 of the cost for approved individual projects. Part I of the Act provides grants for the construction of centers for research on retardation and related aspects of human development, project grants for the construction of university affiliated facilities for the mentally retarded, and grants for the construction of facilities for the mentally retarded, and makes provision for the training of teachers of mentally retarded children. Part III of the Act provides grants for the construction of the community mental health centers. The early versions of the legislation included the provision for financial assistance to underwrite in part the initial staffing of community mental health centers. This provision was eliminated from the Bill which was finally enacted as Public Law 88-164.

Kentucky State Plan

In June, 1963, Governor Bert Combs appointed a Mental Health Planning Commission. Doctor Frank M. Gaines, Jr., was appointed to this Commission as a representative of the Kentucky State Medical Association. The Commission was enlarged in May, 1964, by Governor Breathitt. Meanwhile, a staff under the direction of Mr. Stanley Blostein, serving as a Division of the Kentucky State Department of Mental Health, has begun preliminary investigation of the resources and needs in the mental health field in Kentucky. This has involved several staff studies including an extensive survey of private psychiatric facilities. Information has also been gathered from the Kentucky Manpower Commission, which has been making an independent study of the Mental Health Manpower needs. The Commission is charged with presenting a report to the Governor by the end of June, 1965.

Parallel to this, but not a part of the Mental Health Planning Commission, is a second Commission appointed by Governor Breathitt, which is to plan for mental retardation facilities. The Commissioner of Mental Health is a member of both study Commissions and there are several physician-representatives on the Mental Retardation Planning Commission.

It is still too early to make any detailed report

of the Commission's findings since the studies are still under way. However, it appears to be the intent of the Commission to make an exhaustive study of the mental health needs in Kentucky to determine the gaps which exist in services now and to make recommendations on a long-range basis for a cooperative venture between Federal and State Governments and local communities. This seems to be developing in a parallel manner to the Hill-Burton Hospital Construction Program, which was instituted some years ago.

Frank M. Gaines, M.D.
KSMA Representative

Recommendations, Reference Committee No. 5

The long-range plans for the study of the Mental Health needs of our state is underway and the efforts of this representative are noted in this report.

It is recommended that these efforts be continued so as to make available all resources for Mental Health needs.

Mr. Speaker, I move the adoption and implementation of this section of the report. (Motion seconded and carried.)

Resolution A

KMA Committee on Disaster Medical Care

WHEREAS, in the past few years, our national highway system has enjoyed a tremendous growth in interstate and other limited access highways, and

WHEREAS, this type of highway system will be even more elaborate in the years to come, and

WHEREAS, when sudden illness or injury occurs on these highways, which are no longer routed through our metropolitan areas, there is no easy method for knowing the location of hospitals for emergency treatment, and

WHEREAS, a minimum of time required in securing appropriate medical care and the use of emergency medical equipment such as would be found in a hospital can be life-saving, therefore be it

RESOLVED that the House of Delegates of the Kentucky State Medical Association go on record as requesting that necessary action be taken by the American Medical Association with the appropriate national agency or agencies in an attempt to secure the approval and placement of signs on our nation's major highways designating direction and distance to the nearest hospital, and further that an appropriate symbol be designed to show hospital location on maps, and further be it

RESOLVED that following its approval, this resolution be presented by the Kentucky Delegation to the next session of the House of Delegates of the American Medical Association.

Recommendations, Reference Committee No. 5

Although there are some aspects of this resolution that have not been spelled out as to detail, this reference committee recommends the adoption of this resolution because of agreement with its basic principles.

Mr. Speaker, I move the adoption and implementation of Resolution A. (The motion was seconded.)

During the discussion, Irving Kanner, M.D., Fayette County, made an amendment that Resolution A be accepted with the addition that the word "licensed" be placed before the word "hospital" in the resolved portion of the resolution. His amendment received a second. The vote on the amendment carried.

Resolution F

Campbell-Kenton County Medical Society

WHEREAS, the principle of free choice of physician and fee for service is the standard for medical practice in Kentucky, designed to preserve a doctor-patient relationship of the highest quality, and to make each physician fully responsible for his acts and,

WHEREAS, the medical profession has always cared for patients regardless of race, creed, or economic status, and shall continue to do so, and,

WHEREAS, a third party can do no more than to qualify a patient to receive funds for medical services rendered and,

WHEREAS, the physician alone is legally and morally responsible for the quality of medical service and,

WHEREAS, the medical profession pledges itself to the preservation of principles which have resulted in medical service of the highest quality, Therefore be it

RESOLVED, That the Kentucky Medical Association Board of Trustees evaluate any new plan to provide medical service by any public, private or governmental agency, at the request of any component Society of the Kentucky Medical Association.

This evaluation would determine whether the plan was consistent with the continual high standards of medical practice and in the best interest of the public. If not the Board of Trustees would inform the membership that participation be withheld.

We further recommend that a similar resolution be adopted on a national level by the American Medical Association, to be submitted by our American Medical Association delegates.

Recommendations, Reference Committee No. 5

This was reviewed in detail and the broad principle as outlined in this resolution was thought to be important enough for acceptance by this body of delegates.

Mr. Speaker, I move the adoption and implementation of Resolution F. (The motion was seconded and carried.)

Mr. Speaker, I move the adoption of Reference Committee No. 5 as a whole as modified. (The motion was seconded and carried.)

The Chairman of Reference Committee No. 5 wishes to thank all the committee members for their fine cooperation and assistance.

Reference Committee No. 5
David W. Kinnaird, M.D., Louisville, Chairman
Walter L. Boswell, M.D., Lexington
Carl J. Brueggemann, M.D., Covington
Owen Davis, M.D., Scottsville
Claude C. Waldrop, M.D., Williamstown

REFERENCE COMMITTEE NO. 6 †

N. L. Bosworth, M.D., Chairman
Reports on Constitution and Bylaws; Special Committees

† *See note (†) bottom of column one, page 962.*

Reference Committee No. 6 considered the following reports:

17. Report of the Advisory Committee to the Editor
18. Report of the Professional Relations Committee
19. Report of the Committee on Third Party Medicine
20. Report of the Constitution and Bylaws Committee
    Proposed Change in the Recommendation Offered in the Report of the Constitution and Bylaws Committee by the Delegates from Jefferson County Regarding Mandatory Orientation
14. Report of the Medical Discipline Committee Beginning on Page 3, Including its Nine Recommendations and the Proposed Bylaw Changes Beginning on Page 19
21. Report of the Interim Meeting Program Committee
22. Report of the Insurance Review Board
31. Report of the KSMA Representative on Kentucky Poison Control Program

Report of the Advisory Committee to the Editor

The Board of Trustees, at its first meeting following the last session of the House, directed that this Committee consult with the Editor in studying the cost of *Journal* production, and report to the Board specific recommendations for reducing *Journal* expenses.

The Advisory Committee reviewed the finances of the *Journal* in a daylong conference with the entire editorial staff. Detailed cost information had been prepared by the Managing Editor, and the entire group reviewed the cost and contents of the *Journal* in great detail. From these deliberations we were able to submit the following recommendations to the Board:

"A. That the *Journal* continue publication of the complete actions of the House of Delegates and the Constitution and Bylaws in each December issue. After weighing this material seriously, we feel that it should be available to every member of this Association.

"B. That the Scientific Section be reduced to nineteen pages, two of which will contain the Case Discussion.

"C. That the Maternal Mortality and Public Health pages appear in alternate issues.

"D. That the Insurance Page and the Blue Shield 'Question and Answer' page appear in alternate issues.

"E. That the Editorial, Special Article, and the Organization sections be carried as they have been, with Editorial vigilance in space conservation.

"F. That the Washington Page be omitted at editorial discretion.

"G. That the Book reviews be continued.

"We feel that Student KSMA subscriptions, already in effect at the rate of $4.00 for four years should be honored, but the offer should be discontinued. We advise that a package of *Journals* be available to interested students in each school through the Librarian. We suggest that the matter of student subscriptions is a part of the over-all problems of orienting students toward organized medicine, and that the Advisory Committees to the Medical Schools could advise the Editor on how the *Journal* could best help.

"County Society Reports could be an important help in drawing the members of the Association into a closer relationship. We request that the Trustees endeavor to stimulate reports to the *Journal* from their component societies."

These recommendations were adopted by the Board April 23rd and the Editor is implementing them.

The Sixtieth Anniversary Issue appeared in November, and was exceptionally well received. Doctor Eugene Conner, who served as Special Editor for that issue has received the thanks of this Committee, and of the Board of Trustees, for the excellent production. He is continuing to help as Book Review Editor.

The pattern of *Journal* income for the year indicates that the decline in revenue should soon be halted. Some improvement in revenue may be rather gradually anticipated, but the increase will be slow and probably not involve a recovery to the lush income previously enjoyed. The Managing Editor has been elected a Director of the State Medical Journal Advertising Bureau. As he is the only non-physician on the Board of this organization, we think this represents another recognition of the quality of the Kentucky Journal, and of his personal competence, as judged by his peers in this field.

Your Committee has again been impressed by the zeal and devotion of all members of the Editorial Staff. We have again found that the Kentucky Journal is outstanding among state journals. We feel that this is an indication that, to the Editorial Staff, the *Journal* is a labor of love, and not just another job.

Advisory Committee To The Editor
Blaine Lewis, Jr., M.D., Louisville
Andrew M. Moore, M.D., Lexington
Willett H. Rush, M.D., Frankfort
Orson P. Smith, M.D., Louisville
George F. Brockman, M.D., Greenville, Chairman

Recommendations of Reference Committee No. 6

This report was studied in detail and the committee made note of the recommendations that were made namely (a) that the Journal continue publication of the complete actions of the House of Delegates and the Constitution and Bylaws in each December issue, (b) that the scientific section be reduced to 19 pages, (c) that the Maternal Mortality and Public Health pages appear in alternate issues, (d) that the Insurance page and the Blue Shield "Question and Answer" page appear in alternate issues, (e) that the Editorial, Special Article, and the Organization sections be carried as they have been, (f) that the Washington page be omitted at editorial discretion and (g) that the Book Reviews be continued. It was felt by this committee that the student subscriptions already in effect for four years should be honored but the offer should be discontinued in the future.

That a request was made that the trustees endeavor to stimulate reports to the Journal by component societies.

It is encouraging to note that the income from the Journal for the year indicates that the decline in revenue should soon be halted. This report was approved by the Board of Trustees on August 6, 1964.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried.)

Report of the Professional Relations Committee

No issues were referred to this committee and no meetings were held.

Professional Relations Committee
E. B. Mersch, M.D., Covington, Chairman
Irvin Abell, Jr., M.D., Louisville
David M. Cox, M.D., Louisville
Robert W. Robertson, M.D., Paducah
G. L. Simpson, M.D., Greenville

Recommendations, Reference Committee No. 6

It was noted that no issues were referred to this committee and no meetings were held. Board action: Approved.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Report of the Committee on Third Party Medicine

To our knowledge, providers of Third Party Medicine have not been a major problem since the last session of the House of Delegates. For this reason, our Third Party Committee did not have a meeting.

The UMWA hospitals, which formerly created many of our problems, have new ownership, and the hospital chain is now known as Appalachian Regional Hospital, Incorporated. Our KSMA Hospital Committee and Executive Committee of the Board of Trustees have been meeting with the ARHI representatives since most of the hospital matters pertain to these two committees.

Although our Third Party Committee has been inactive during the past year, it is recommended that

this Committee be continued and stand ready for any Third Party problem which may arise.

COMMITTEE ON THIRD PARTY MEDICINE
Ballard W. Cassady, M.D., Pikeville
Walter L. Boswell, M.D., Lexington
Robert Jasper, M.D., Somerset
Robert E. Norsworthy, M.D., Hartford
John S. Harter, M.D., Louisville, Chairman

Recommendations, Reference Committee No. 6

This reference committee noted that there had been no major problems since the last session of the House of Delegates and no meetings were held. Board action: Approved.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried.)

Report of the Constitution and Bylaws Committee

Your committee held one meeting on the 10th of June to continue its study of the Constitution and Bylaws and to implement the matters referred to it by the Board of Trustees.

Clarification of Membership

The committee gave lengthy consideration to how the Bylaws might be written to avoid apparent misunderstandings relative to the relationship of membership in the state association and the county society. The first sentence of Chapter I, Section 1 covering this matter reads as follows:

"A member of this Association must also be a member of one of the component societies and when certified to the Secretary of the Association as a member of a component society, properly classified as to type of membership, and when the dues pertaining to his membership classification have been received by the Secretary of the Association, the name of the member shall be included in the official roster of the Association and he shall be entitled to all the privileges of his class of membership."

In order to fully delineate this matter, the committee proposes the following amendment to the first sentence, which would read as follows:

Membership in this association shall be coterminous with membership in a component county society. No physician shall be eligible for membership in this association unless he is a member, in good standing of a component society, nor may he maintain membership in a component county society unless he is a member, in good standing of this association.

When a physician who meets the qualifications hereinafter set forth, is certified to the Secretary as a member in good standing of a component society, properly classified as to type of membership, and when the dues pertaining to his membership classification have been received by the Secretary of the Association, the name of the member shall be included in the official roster of the Association and he shall be entitled to all the privileges of his class of membership.

(The italic type indicates the proposed rewording of the sentence).

Recommendations, Reference Committee No. 6

This report was carefully reviewed and the first recommended change was that of membership contained in the first sentence of Chapter 1, Section 1 of the Bylaws. As the Bylaws now read:

"A member of this Association must also be a member of one of the component societies and when certified to the Secretary of the Association as a member of a component society, properly classified as to type of membership, and when the dues pertaining to his membership classification have been received by the Secretary of the Association, the name of the member shall be included in the official roster of the Association and he shall be entitled to all the privileges of his class of membership."

Recommended change is as follows:

MEMBERSHIP IN THIS ASSOCIATION SHALL BE COTERMINOUS WITH MEMBERSHIP IN A COMPONENT COUNTY SOCIETY. NO PHYSICIAN SHALL BE ELIGIBLE FOR MEMBERSHIP IN THIS ASSOCIATION UNLESS HE IS A MEMBER, IN GOOD STANDING OF A COMPONENT SOCIETY, NOR MAY HE MAINTAIN MEMBERSHIP IN A COMPONENT COUNTY SOCIETY UNLESS HE IS A MEMBER, IN GOOD STANDING OF THIS ASSOCIATION. WHEN A PHYSICIAN WHO MEETS THE QUALIFICATIONS HEREINAFTER SET FORTH, IS CERTIFIED TO THE SECRETARY AS A MEMBER IN GOOD STANDING OF A COMPONENT SOCIETY, PROPERLY CLASSIFIED AS TO TYPE OF MEMBERSHIP, and when the dues pertaining to his membership classif-, etc. . . .

Mr. Speaker, I move the adoption and implementation of this section of the report. (Motion was seconded and carried.)

Report of the Constitution and Bylaws Committee (Continued)

Professional Relations Committee

Due to the changes in grievance procedures approved by the 1963 House of Delegates, the committee felt that the Professional Relations Committee no longer served a purpose. However, until final recommendations for Bylaws change were received from the Committee on Medical Discipline, it was decided that no change in the Professional Relations Committee would be recommended at this time.

Recommendations, Reference Committee No. 6

No change in the Professional Relations Committee was recommended.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded and carried.)

Report of the Constitution and Bylaws Committee (Continued)

Mandatory Orientation

Following a lengthy period of study by the Council on Communications and Public Service, the 1963 session of the House accepted the Council's recommendation that the Association proceed with a mandatory orientation program for all new members. In accordance with a special study by a sub-committee of the Council on Communications and the Council itself, the Bylaws Committee recommends that the following new section implementing the 1963 action of the House of Delegates on mandatory orientation be added to the Bylaws and be known as Section 5 of Chapter 1.

5. *Every active member shall occupy a provisional status for two years immediately following his admission to membership in the Association, during which period he must successfully complete an orientation course to be presented at stated intervals by the Board of Trustees or one of its committees. The form and content of this course shall be prescribed by the Board and unless excused by the Board for good cause shown, failure to attend and successfully complete the course within the two-year period shall automatically revoke the delinquent's membership and terminate all of his rights and privileges as a member, and he shall thereafter, for a period of one year, be ineligible for membership in any component county society.*

Amendment of Mandatory Orientation Proposal Submitted by the Delegates from Jefferson County Medical Society

The Delegates from the Jefferson County Medical Society agree in principle with the recommendation of the Council on Communication concerning a new member orientation program. We wish to point out that this Society has an orientation program for new members which not only explains the purpose and operation of the County Society but also covers important and necessary points concerning the Kentucky State Medical Association. We feel that for new members of this County Society to attend a mandatory orientation program of the State Association would be a duplication of effort and unnecessary inconvenience to the new physician.

This Society Delegation is in sympathy with the intent and purpose of this recommendation and agrees with the new Bylaw section as printed in report Number 20, Page 2, however desires to amend this new section in order that a State Association Trustee might attend and participate in the Jefferson County Society program thus fulfilling the orientation needs for all new members in our society.

We therefore offer an amendment to the new section of the Bylaws which is to be known as Section 5 of Chapter 1. Section 5 would then read as follows (our amendment shown by italics):

5. Every active member shall occupy a provisional status for two years immediately following his admission to membership in the Association, during which period he must successfully complete an orientation course to be presented at stated intervals by the Board of Trustees or one of its committees, *or an approved orientation course of a component County Society, supervised by and under direction of Board of Trustees.* The form and content of this course shall be prescribed by the Board and unless excused by the Board for good cause shown, failure to attend and successfully complete the course within the two-year period shall automatically revoke the delinquent's membership and terminate all of his rights and privileges as a member, and he shall thereafter, for a period of one year, be ineligible for membership in any component county society.

Recommendations, Reference Committee No. 6

Mandatory Orientation. The committee again studied this in detail and felt that the proposed change recommended in the report of the Constitution and Bylaws Committee should remain as recommended namely:

(Chapter I, Section 5)

EVERY ACTIVE MEMBER SHALL OCCUPY A PROVISIONAL STATUS FOR TWO YEARS IMMEDIATELY FOLLOWING HIS ADMISSION TO MEMBERSHIP IN THE ASSOCIATION, DURING WHICH PERIOD HE MUST SUCCESSFULLY COMPLETE AN ORIENTATION COURSE TO BE PRESENTED AT STATED INTERVALS BY THE BOARD OF TRUSTEES OR ONE OF ITS COMMITTEES. THE FORM AND CONTENT OF THIS COURSE SHALL BE PRESCRIBED BY THE BOARD AND UNLESS EXCUSED BY THE BOARD FOR GOOD CAUSE SHOWN, FAILURE TO ATTEND AND SUCCESSFULLY COMPLETE THE COURSE WITHIN THE TWO-YEAR PERIOD SHALL AUTOMATICALLY REVOKE THE DELINQUENT'S MEMBERSHIP AND TERMINATE ALL OF HIS RIGHTS AND PRIVILEGES AS A MEMBER, AND HE SHALL THEREAFTER, FOR A PERIOD OF ONE YEAR, BE INELIGIBLE FOR MEMBERSHIP IN ANY COMPONENT COUNTY SOCIETY.

The proposed change in the recommendation offered in the report of the Constitution and Bylaws Committee by the Delegates from Jefferson County Regarding Mandatory Orientation was as follows:

5. EVERY ACTIVE MEMBER SHALL OCCUPY A PROVISIONAL STATUS FOR TWO YEARS IMMEDIATELY FOLLOWING HIS ADMISSION TO MEMBERSHIP IN THE ASSOCIATION, DURING WHICH PERIOD HE MUST SUCCESSFULLY COMPLETE AN ORIENTATION COURSE TO BE PRESENTED AT STATED INTERVALS BY THE BOARD OF TRUSTEES OR ONE OF ITS COMMITTEES, *OR AN APPROVED ORIENTATION COURSE OF A COMPONENT COUNTY SOCIETY.** THE FORM AND CONTENT OF THIS COURSE SHALL BE PRESCRIBED, ETC. . . .

After considerable deliberation, it was felt by this committee that this proposal would weaken the objectives of such a course and in addition would duplicate efforts.

Mr. Speaker, I move the adoption and implementation of this section of the report as originally written. (Motion was seconded and carried.)

**Note: James M. Riley, M.D., Jefferson County, pointed out that the amendment from Jefferson County on mandatory orientation should read . . . "or an approved orientation course of a component county society supervised by and under direction of Board of Trustees."*

Report of the Constitution and Bylaws Committee (Continued)

Number of People to Serve on the Council

Chapter VII, Section 1 provides that no less than five and no more than seven members may serve at any one time on one of the Councils of KSMA. The 1963 meeting of the House of Delegates accepted a recommendation from the Council on Medical Education and Hospitals that both deans be added to the Council, which would bring the total membership to eight.

This was also discussed at length by the Bylaws Committee, which recommends that the number of people to serve on a Council remain at the present Bylaw limit and that one of the chairmen of the committees under the Council also serve as chairman of the Council.

Recommendations, Reference Committee No. 6

Number of People to Serve on any of the Six KSMA Councils. Recommendation the same.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Report of the Constitution and Bylaws Committee (Continued)

Procedure for Reporting House of Delegates Digest in Journal of KSMA

The Bylaws Committee gave consideration to present procedures for reporting the actions of a committee through the Council, the Board of Trustees, and the House of Delegates in an effort to simplify the procedure. The following recommendation does not involve a Bylaw change but is a recommendation to the Board of Trustees. In reporting the actions of the 1964 House of Delegates in The Journal on the work of the various councils and standing committees, it is recommended that if no dissenting action to the committee's recommendations is made either by the Council under which the committee serves or the KSMA Board of Trustees, that only the reference committee action on the report be printed in The Journal. Appropriate note would be made of this new procedure at the beginning of the report.

The purpose of this recommendation is to shorten the report and make it easier to understand.

Recommendations, Reference Committee No. 6

Procedures for Reporting the House of Delegates

Digest in the Journal of KSMA. There is no Bylaw change involved in this recommendation and it is merely a recommendation to the Board of Trustees to the effect that in reporting the actions of the 1964 House of Delegates in the Journal on work of the various councils and standing committees, it is recommended that if no dissenting action to the committee's recommendations is made either by the council under which the committee serves or the KSMA Board of Trustees. that only the reference committee action on the report be printed in the Journal.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried.)

Report of the Constitution and Bylaws Committee
(Continued)

Change in Constitution

The 1963 House of Delegates adopted the following recommendation made by the Committee to Study the Constitution and Bylaws "that in order to avoid confusion by lay people in thinking this is a part of state government the name of Kentucky State Medical Association be shortened to that of Kentucky Medical Association".

Article XII of the Constitution says that it may be amended provided the following conditions are met: 1. That the recommendation lay over for a period of a year; 2. That each county society be given official notice of the proposed change at least two months in advance. Both of these provisions have been met.

Your Bylaws Committee now recommends that the name of the Association be changed from the Kentucky State Medical Association to the Kentucky Medical Association. The Constitution provides that it takes a two-thirds vote of the delegates registered at the session to change the Constitution.

Your committee also recommends that it be given permission to delete the word "state" wherever it appears in the title of our association in the Bylaws.

Recommendations, Reference Committee No. 6

Change in Constitution. The committee was in whole-hearted support of the change of the name of the Kentucky State Medical Association to the Kentucky Medical Association. The requirements for this Constitutional change have been met.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Report of the Constitution and Bylaws Committee
(Continued)

Status of KSMA Woman's Auxiliary

It was explained to the committee that all official KSMA records up to January of 1937 were destroyed in the flood. At that time the association's offices were located in the basement of the State Department of Health Building at Sixth and Main.

The General Counsel stated that he was unable to find any record of the Woman's Auxiliary being an official adjunct of KSMA and he felt that there should be some official action indicating that the Auxiliary was an official adjunct of the organization. All members of the committee were convinced that at some time prior to 1937 appropriate action in this connection had been taken by the Association despite the fact there was no record of it.

While the committee does not recommend an amendment to the Bylaws in this connection, it would recommend that the following resolution adopted by the KSMA Board of Trustees, be approved by the House of Delegates as the Association's policy in this matter:

WHEREAS, the Woman's Auxiliary to KSMA has for many years preformed numerous useful and constructive services to organized medicine in this state, and

WHEREAS, there appears to be nothing on record which acknowledges the Auxiliary's status with respect to the Association, and

WHEREAS, the Board of Trustees deems it desirable that its long-established recognition be reaffirmed of record,

NOW THEREFORE BE IT RESOLVED that the Board of Trustees, on behalf of the Association, extend recognition to the "Woman's Auxiliary to the Kentucky State Medical Association" as an organization of wives, daughters and widows of members of this Association affiliated with but not a part of said association, so long as said Auxiliary's aims and purposes remain consistent with and complementary to those of the Association, with the request that it furnish the Association a copy of its charter and bylaws and all amendments, and report its activities at least annually to the Board.

COMMITTEE TO STUDY THE CONSTITUTION AND BYLAWS
James S. Baughman, III, M.D., Harrodsburg
Bruce Hamilton, M.D., Shepherdsville
Douglas H. Jenkins, M.D., Richmond
James G. Sills, M.D., Hardinsburg
E. C. Strode, M.D., Lexington
Robert S. Dyer, M.D., Louisville, Chairman

Recommendations, Reference Committee No. 6

Status of the Woman's Auxiliary. The committee whole-heartedly endorsed the recommendation of this committee to officially recognize the KSMA Woman's Auxiliary. Board action: Approved.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried.)

Report of the Medical Discipline Committee of the Council on Medical Services

Medical Discipline Committee, Robert E. Pennington, M.D., London, Chairman

The Medical Discipline Committee met on Wednesday, May 27. Prior to making its recommendations, the committee felt that the following background information would be helpful.

In 1961 Laurel County Medical Society introduced a resolution asking the House of Delegates to instruct its president to cause a bill to be drafted for the legislature to enact a law creating a judicial body within the medical profession of Kentucky. The committee would be given the power to subpoena, hear testimony, judge inept medical practices, as well as unethical conduct, and be able to enforce disciplinary action such as fines, suspensions, or revocations of licenses. The resolution further asked that doctors who served on the committee possess immunity under the law from civil action.

The idea for this resolution came as a result of several states, particularly Washington, passing such laws giving physicians power to discipline the members of their profession. We later found the State Board of Health has authority to do everything called for in the resolution with the exception of some things concerning medical ethics.

It is a recognized fact that most county societies have memberships too few in number to have effective judicial committees. Because of this, the KSMA Board of Trustees created fifteen trustee district grievance committees, each composed of three trustees. At the time these committees were initiated, it was felt that each could render decisions on its own; however, the plaintiff could take his appeal to the Board of Trustees. Some of the grievance committees did not desire to render the final decisions and asked that the Trustees make these decisions. There were no guidelines for uniformity among the different committees.

Mr. Davis said he recommended that the rules be changed and the grievance committee only make recommendations to the Board of Trustees. He said this would take a little longer to get a final decision,

but the doctor involved would know that an even hand was applying discipline. So, having solved one problem, we created another because the Board of Trustees had too much to do already. The problem now is how to maintain a workable and aggressive disciplinary system without overburdening the Board and still assuring a doctor who is in trouble that a standard of discipline would apply to him the same as to a doctor in another area.

This committee is one of many under the Council on Medical Services. Some time ago the Council outlined the proposed duties of this committee and, with one change by the Board of Trustees at its meeting on April 22, the duties are as follows:

This committee shall have the responsibility of investigating, with the assistance of the Association's legal counsel when necessary, the adequacy of disciplinary rules, laws, and procedures as applied to medical practice, licensure, and medical society membership, and the degree to which efficient discipline is maintained among medical practitioners as may be referred to it by proper agencies of the Association, and make recommendations to the Board of Trustees.

Bylaws of judicial committees were obtained from California and New York Medical Associations and each member of the committee was given a copy. Mr. Davis said evidently the AMA thought the Texas Medical Association had good bylaws for a judicial council because they were on the program during a recent AMA meeting dealing with this subject. Doctor Pennington asked that Headquarters Office photocopy the Texas bylaws on discipline and mail same to each member on the committee. Doctor Pennington then commented on the structure and procedures of operation of the judicial councils in the states mentioned above.

Mr. Davis had a copy of "Conclusions and Recommendations in the Report of the Medical Discipline Committee to the Board of Trustees, American Medical Association, June, 1961." From this he read portions which would be helpful to any state in the way of guidelines for forming a judicial council.

After considering all of the foregoing, this committee makes the following recommendations:

1. That all KSMA committees dealing with disciplinary problems, with the exception of the district grievance and insurance review committees, be abolished.

2. That all disciplinary powers and functions of the Board of Trustees be transferred to a Judicial Council composed of the Secretary of the Association and four members to be elected by the House of Delegates, upon nomination of the Board of Trustees, for terms of four years. Additional Nomination from the floor should be permitted. One member of the Judicial Council should be nominated from each of the eastern, western, and central districts, and one member at large. Terms of the initial nominees should be staggered so that one man is elected each year, and no member should serve more than two full terms. Vacancies should be filled by the Board. A majority of the members should constitute a quorum.

3. That nominees for election to the Judicial Council have at least one of the following four qualifications: (a) Served five years in House of Delegates; (b) Served one term as an officer, trustee, or delegate to the AMA.

4. That present disciplinary appellate procedures remain the same, with the exception that appeals be taken to the Judicial Council instead of the Board of Trustees, the decision of the Judicial Council being final except for any appeal to the Judicial Council of the AMA.

5. That the Judicial Council be placed administratively on the same level as other councils and report to the House of Delegates via the Board of Trustees.

6. That the Judicial Council be given authority to initiate disciplinary proceedings against any member, and to intervene in and supersede county or district disciplinary proceedings whenever, in the opinion of the council, a disciplinary matter is not being handled in an expeditious manner.

7. That if the Judicial Council should find that a member's license should be revoked, it reports this to the Board of Trustees as a recommendation that the Board refer the matter to the State Board of Health for this purpose.

8. That the larger county societies be encouraged to form grievance committees and advised that the district grievance committees should be utilized only when the manner cannot be handled at the county level.

9. That the Insurance Review Committee be instructed to refer all matters coming to its attention which appear to merit disciplinary action, to the Judicial Council for appropriate action which may include referral to the county or district grievance committee.

It was also taken by common consent that the Council on Medical Services recommend that the proposed Bylaws changes outlined below be voted upon at this 1964 Annual Meeting in order that the report of the Medical Discipline Committee can be implemented during the 1964-1965 Associational year.

PROPOSED AMENDMENTS TO KSMA BYLAWS

1. Chapter VI, Section 4: Strike this section in its entirety and re-number succeeding sections.

2. Chapter VII, Section 1: Strike subsection (c) and re-letter succeeding subsections.

3. Chapter VII, Section 9: Strike this section in its entirety and re-number succeeding sections.

4. Create a new Chapter VII (by re-numbering present Chapter VII and succeeding chapters) as follows:

CHAPTER VII. DISCIPLINE—THE JUDICIAL COUNCIL

"Section 1. There is hereby created a Judicial Council composed of the Secretary of the Association and four members to be elected by the House of Delegates for terms of four years each. One member shall be elected from each of the traditional eastern, western, and central districts, and one member from the state at large. Members of the first Judicial Council shall be elected for terms of one, two, three, and four years, respectively, so that thereafter, one member will be elected each year. The Council shall annually elect a chairman.

"To be eligible for membership on the Judicial Council, a nominee shall possess at least one of the following qualifications: (1) Have served one term as an officer, trustee, or as Delegate to the AMA or (2) Have served five years as a member of the House of Delegates.

"It shall be the duty of the Board of Trustees to nominate at least one candidate for each vacancy on the Judicial Council, but additional nominations may be made from the floor. Vacancies which occur between Regular Sessions of the House of Delegates, shall be filled by the Board of Trustees. No member, other than the Secretary, shall serve more than two consecutive terms.

"Section 2. The Judicial Council shall be the Board of Censors of the Association. It shall be the final arbiter of all questions involving the right and standing of members, whether in relation to other members, to the component societies, or to this Association. All questions of an ethical nature brought before the House of Delegates shall be referred to the Judicial Council without discussion. A member who has been convicted of a felony or of any violation of the Medical Practice Act, or who violates any of the provisions of the constitution, bylaws, or any rule or regulation of this Association, or the Principles of Ethics of the American Medical Association shall be liable to censure, fine, suspension, or expulsion upon order of the Judicial Council. Provided, however, that if in addition to discipline by the Association, the Judicial Council shall be of the opinion that the offend-

ing member's license to practice medicine should be revoked, it shall report this to the Board of Trustees as a recommendation that the Board refer the matter to the State Board of Health for this purpose.

"It may initiate disciplinary proceedings against any member, and may intervene in or supersede county, individual trustee, or district disciplinary proceedings whenever in its sole judgment and opinion, a disciplnary matter is not being handled in an expeditious manner, and may render a decision therein. In all such cases of initiation, intervention, or supersession, the due process requirements of reasonable notice and a full and fair hearing shall be observed. No recommended disciplinary decision of an individual trustee or any district grievance committee shall become effective unless and until approved by the Judicial Council.

"Section 3. It shall consider all appeals from the recommended decisions of individual trustees and District Grievance Committees. In the case of appeals from the decisions of individual trustees, the Judicial Council may admit such oral or written evidence as in its judgment will best and most fairly present the facts, but all appeals from the recommended decisions of District Grievance Committees shall be considered on the record made before such committee. It shall be the duty of the Secretary to notify the parties with respect to its disposition of each case.

"Section 4. The Judicial Council may hear appeals from the disciplinary orders of component societies. Provided, however, that such appeals shall be considered on the record made before the component societies.

"Section 5. Efforts toward conciliation and compromise shall precede the hearing of all disciplinary cases, but the decision of the Judicial Council shall be final.

"Section 6. Component societies are encouraged to create suitable disciplinary procedures which guarantee due process, and to dispose of all disciplinary problems which come to their attention. It is recognized, however, that it may not be feasible for some societies to do so, and the District Grievance Committees hereinafter created, are designed to meet the needs of county societies which are without a functioning grievance committee.

"Section 7. The trustee of each district is hereby designated the chairman of his District Grievance Committee. The Judicial Council shall designate two additional trustees from districts adjoining that of the chairman, and the three trustees thus selected shall constitute the District Grievance Committee. All grievances which cannot be resolved by individual trustees, shall be referred to the local grievance committee or the district grievance committee for the district in which the respondent physician or county society resides.

"Section 8. District Grievance Committees shall investigate every grievance coming to their attention, taking care that the physician complained of shall have ample opportunity to respond to the complaint. If, after careful investigation, the complaint appears to be without merit, the committee shall so report to the Judicial Council, including sufficient facts in its report to enable the Judicial Council to form its own conclusions.

"If the District Grievance Committee's investigation indicates that the member may be a proper subject of disciplinary action, the committee shall, upon reasonable notice, hold a hearing at which the complainant and the respondent shall each be entitled to the counsel of any physician of his choice, to present the testimony of witnesses in his behalf, and to cross-examine witnesses against him. All testimony shall be under oath and shall be recorded by a competent reporter at the expense of the Association, but shall not be transcribed unless and until an appeal is taken as hereinafter provided.

"When all of the testimony has been heard and all evidence received, the committee shall make written findings and recommendations which it shall transmit to the Judicial Council, furnishing copies thereof to the parties.

"Section 9. Any party aggrieved by the findings or recommendations of the committee, may, within 30 days, appeal to the Judicial Council. Appeals shall be taken by filing with the Secretary a copy of the entire record made before the District Grievance Committee (including a transcript of the testimony, procured at the appellant's expense) together with a written statement of appeal pointing out in detail wherein the committee has erred, and directing the attention of the Judicial Council to those portions of the transcript upon which he relies."

5. Chapter XI (new XII), Section 7: Strike parenthetical sentence at end.

6. Chapter XI (new XII), Section 6: Amend proviso to read: "Provided, however, that no physician who is under suspension or who has been expelled shall thereafter, without reinstatement by the Board of Trustees, be eligible for membership in any component society."

7. Chapter XI (new XII), Section 10: Substitute "Judicial Council" for "Board of Trustees" in paragraphs 3 and 4, leaving paragraph 5 as is.

Recommendations, Reference Committee No. 6

This committee heard arguments both pro and con on paragraph two, page 21, Report No. 14, which states:

> "It may *initiate* disciplinary proceeding against any member, and may *intervene* in or *supersede* county, individual trustee, or district disciplinary proceedings whenever in its sole judgment and opinion, a disciplinary matter is not being handled in an expeditious manner, and may render a decision therein. In all such cases of initiation, intervention, or supersession, the due process requirements of reasonable notice and a full and fair hearing shall be observed. No recommended disciplinary decision of an individual trustee or any district grievance committee shall become effective unless and until approved by the Judicial Council."

After due consideration, the committee proposes the following substitution in paragraph 2, page 21, Report No. 14.

> AT THE REQUEST OF ANY MEMBER OR AGGRIEVED INDIVIDUAL INVOLVED, THE JUDICIAL COUNCIL may initiate disciplinary proceedings against any member, and may intervene in or supersede county, individual trustee, or district disciplinary proceedings whenever in its sole judgment and opinion, . . .

This committee based its conclusion not on personalities involved but on principles involved.

Mr. Speaker, I move the adoption and implementation of this section of the report. (Motion was seconded and carried.)

Section 9, page 23, Report No. 14 reads:

> "Any party aggrieved by the findings or recommendations of the committee, may, within 30 days, appeal to the Judicial Council. Appeals shall be taken by filing with the Secretary a copy of the entire record made before the District Grievance Committee (including a transcript of the testimony, procured at the appellant's expense) together with a written statement of appeal pointing out in detail wherein the committe has erred, and directing the attention of the Judicial Council to those portions of the transcript upon which he relies."

This committee would recommend the addition to Section 9 as follows:

> . . . "directing the attention of the Judicial Council to those portions of the transcript upon which he relies, 'PROVIDED, HOWEVER, THAT THE JUDICIAL COUNCIL MAY EXTEND THE TIME IN WHICH THE TRANSCRIPT MUST

BE FILED, UPON REQUEST MADE WITHIN THE INITIAL THIRTY-DAY PERIOD.'"

The thinking behind this was that in many instances where the transcript involved quite a tremendous amount of material, that it would take longer than thirty days for this transcript to be prepared.

Mr. Speaker, I move the adoption and implementation of this section of the report. (Motion seconded; carried.)

Report of the Interim Meeting Program Committee

Your committee met late in the fall of 1963 to plan the 1964 meeting which was held at Jenny Wiley State Park, April 23. (The Committee also met at the Park.)

The program was carefully planned and a vigorous promotion was scheduled. Plans for housing the overnight guests were made and duties were delineated and assigned.

As a result of all of these efforts, a new high in registration for the meeting of 215 was reached. The speakers at the Conference were outstanding.

Your committee would like to thank all who worked so hard to make this meeting enjoy this unusual success.

INTERIM MEETING COMMITTEE
James D. Adams, M.D., Prestonsburg
William Hambley, M.D., Pikeville
Douglas E. Scott, M.D., Lexington
George P. Archer, M.D., Prestonsburg, Chairman

Recommendations, Reference Committee No. 6

This report deals with the Interim Meeting held at Jenny Wiley State Park and congratulates the committee responsible for this meeting. Board action: approved.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Report of the Insurance Review Board

The Kentucky State Medical Association Insurance Review Board came into being in August, 1963. A Canvass by mail revealed the members were of the opinion we need meet only when the matter under consideration required discussion in detail. Accordingly, the Board has held one meeting. We have considered a total of three complaints submitted to us.

Each member of the Board has been asked to submit criticisms and suggestions concerning the form and function of this Board. These will be attached, if any.

INSURANCE REVIEW BOARD
Bernard J. Baute, M.D., Lebanon
Harvey Chenault, M.D., Lexington
John Dickinson, M.D., Glasgow
Albert S. Irving, M.D., Louisville
Paul H. Klingenberg, M.D., Covington
Alfred O. Miller, M.D., Louisville
Jack L. Chumley, M.D., Louisville, Chancellor

Recommendations, Reference Committee No. 6

One meeting was held. Board action: approved.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Report of KSMA Representative on Kentucky Poison Control Program

While the Kentucky Poison Control Council has been reasonably active during the past year, there have been no dramatic developments and all business has been of a routine matter. We have enjoyed our association on this Council.

Arnold C. Williams, M.D.
KSMA Representative

Recommendations, Reference Committee No. 6

There have been no new developments brought out to this committee.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried.)

As chairman, I would like to express appreciation to the members of this committee for their diligent, dedicated work on this committee.

Mr. Speaker, I move the adoption and implementation of this report as amended. (The motion was seconded and carried.)

REFERENCE COMMITTEE NO. 6
N. L. Bosworth, M.D., Lexington, Chairman
J. S. Baughman, M.D., Harrodsburg
J. C. Cantrill, M.D., Georgetown
Ralph D. Lynn, M.D., Elkton
Henry Post, M.D., Louisville

REFERENCE COMMITTEE NO. 7 †

L. F. Beasley, M.D., Chairman
Miscellaneous Reports

† *See note (†) bottom of column one, page 962.*

The reports this reference committee considered are as follows:

25. Report of the McDowell Home Committee
26. Memorials Commission
28. KSMA Representative to Conference of Presidents and Other Officers of State Medical Association
29. KSMA Representative, University of Kentucky Chapter Student AMA
30. KSMA Representative, University of Louisville Chapter, Student AMA
33. Representative, Advisory Committee on Maternal and Child Health, State Department of Health

Reference Committee No. 7 has studied reports Nos. 25, 26, 28 (less paragraph 3 on page 4 and the accompanying financial report), 29, 30 and 33.

Report of the McDowell Home Committee

Your Committee views with pride the restoration of the Ephraim McDowell Home and the re-assembling of those professional and personal possessions of one of the outstanding figures of all time in medicine. Your Committee is proud to follow in the footsteps of the three recent Committees with their distinguished Chairmen, Irvin Abell, Sr., M.D., Charles A. Vance, M.D., and Francis M. Massie, M.D. Over the years numerous other distinguished members of our Association have added greatly to the fruition of the restoration in its present state. These included Samuel Gross, M.D., John D. Jackson, M.D., August Schachner, M.D., J. N. McCormack, M.D., C. C. Howard, M.D., A. T. McCormack, M.D., and many others.

This Committee has had two formal meetings this year and plans a third for early September. The first meeting took place at the Hunt-Morgan House in Lexington, Kentucky on January 18, 1964. The prime purpose was to receive the discovery by Doctor Massie of the McDowell Library, and the second to receive a valuable antique gift by Charles Pfizer Company. To this luncheon meeting were invited Charles N. Tarkington, M.D., a descendant of Doctor McDowell, Dr. Thomas O. Clark, Professor of History, University of Kentucky, Dr. Lawrence Thompson, Librarian of the University of Kentucky, Miss Roeson Henry, Librarian of Transylvania College, Dr.

Omer Hamlin, Jr., Librarian at the University of Kentucky, Mr. Winston Coleman, local historian, George Doyle, M.D., collector of rare books, Mrs. Hill Shine of the Rare Book Room of the University of Kentucky, Mr. Thomas Underwood of the Barkley Room of the University of Kentucky, and members of the press.

Doctor Massie had obtained from Otto Brantigan, M.D., of Baltimore, who in turn had received from the Reverend Michael Barton of Accomac, Virginia, books which composed the library of Ephraim McDowell, M.D. The Reverend Barton had received the books from a granddaughter of Doctor McDowell. She was the daughter of Alexander, and had a sister, Lucy Meader, who was living at the Alms Hotel, Cincinnati around 1940. The library included 26 printed medical books of the late 18th century and one hand-written volume, "A Medical Commonplace Book." The latter may have represented a notebook kept by Doctor McDowell. These books now repose in the Rare Book Room of the Library of Transylvania College. Richard H. Segnitz, M.D., of this Committee, Dr. Norman H. Franke, of the College of Pharmacy of the University of Kentucky, and the local librarians are studying these books for their historical significance.

A second part of that Committee Meeting included the presentation by Walter Bett, M.D., Editor of Spectrum, Charles Pfizer Company, of a rare pill tile, pill cutting machine and pill rounder, to the Kentucky State Medical Association. The Wedgewood tile is one of two of the type known to be existing today. This rare and valuable gift has been added to the unusual display in the Apothecary Shop of the McDowell Home.

A business meeting of the Committee followed these presentations.

A second Committee Meeting was held in the McDowell Home, April 19, 1964, when the house was carefully examined by the members and a long discussion followed.

The expenses of maintaining the McDowell Home approximate $6,000 per year, and it is anticipated these will increase as the restoration becomes older and more maintenance is required. $3,000 is appropriated from the State Medical Association, $1,000 is from the Kentucky Surgical Association, $1,000 from admissions, and the remainder is irregularly contributed by other medical organizations; the latter has been particularly irregular.

In the Spring of 1964 it was necessary to replace deteriorated weather boarding on the south side of the house, some of the brick work, and replace some rotton flooring on the rear porch. This cost just over $1,500 which caused an immediate deficit for a few months. This is the largest repair bill in the last few years, but we must realize that further major repairs may be necessary in the near future. A budget must anticipate this situation.

A Sub-Committee on Finance, consisting of David Kinnaird, M.D., Rankin C. Blount, M.D., and George W. Sweeney, M.D., will submit a budget to the Home Committee for supplies, repairs, painting (needed in the immediate future), personnel, insurance, publicity, telephone, gas and electricity, miscellaneous services, payroll and sales taxes. Finances must be budgeted for probably major repairs at least every three years. It is desirable to obtain funds for a fireproof room and safe for the protection and preservation of some of the most valuable objects, including personal letters of McDowell, his library and even the original oil painting by Davenport, lent to the State Department of Health in Frankfort. Funds for other improvements, enumerated below, may be sought.

A Historical Sub-Committee composed of Doctor Segnitz, Dean Earle P. Sloane of the College of Pharmacy of the University of Kentucky, and Mr. Sterling Coke, are investigating the historical significance of the recently discovered library, are obtaining information on reproduction of the original letters which are fading rapidly, are summarizing information on all authentic McDowell personal properties and letters, and will collect the truly historical information on Cambus Kenneth and its remaining original McDowell buildings.

It is anticipated that a Planning Sub-Committee will offer definitive suggestions in regard to a small kitchenette for use by various committees of the Medical Association and other organizations, for improved powder room facilities, for fireproofing the office or the rear room of the Apothecary Shop, or possibly the construction of a small, fireproof museum room on the rear of the property for the protection of valuable items.

An encouraging new development is the recent action of the Danville and Boyle County Historical Society. On June 14, 1964, the Historical Society endorsed a proposal to establish a memorial in Danville to the first Governor in Kentucky, Isaac Shelby. Resolutions were adopted and forwarded to the Commissioner of State Parks and the Governor, asking that the State give consideration to the enlargement of Constitution Square in Danville, and the erection of a Shelby Memorial in the ground now occupied by commercial buildings between Constitution Square and the McDowell Home.

It was noted that Doctor McDowell's wife was Sarah Shelby, the daughter of Isaac Shelby. This was presented to the Commissioner of State Parks, Robert D. Bell, June 16, 1964. This entire activity was stimulated by Doctor Massie. It is felt that the physicians should remain in the background and aid the historical societies in pressing this project which will be of immense value to the protection of the McDowell Home and add to its increasing attractiveness to tourists to learn of this medical heritage of Kentucky.

It is a matter of pride that the Association should continue to maintain this National and World Shrine in a proper manner. The financial contribution of the Kentucky State Medical Association is obviously necessary, and it is logical to increase this contribution from $3,000 to $4,000 per annum.

Attached is the financial report as prepared by the financial office of the Kentucky State Medical Association.

THE McDOWELL HOME COMMITTEE
Robert Bateman, M.D.
Rankin C. Blount, M.D.
Mr. Sterling Coke
Mr. George Grider
E. M. Howard, M.D.
David Kinnaird, M.D.
Dean Earl P. Sloane
Richard H. Segnitz, M.D.
George W. Sweeney, M.D.
Laman A. Gray, M.D., Chairman

Recommendations, Reference Committee No. 7

Reference Committee No. 7, has studied the report of the McDowell Home Committee and we recognize and appreciate the work that has been done by the Committee. We also recognize the significance of the McDowell Home and Apothecary from the standpoint of the history of medicine in Kentucky and the world. We also note the recommendations of the Committee and note the deficit involved. In reference to the request for funds, this portion of the report was referred to Committee No. 1.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded and carried.)

Report of the Memorials Commission

Your commission held its meeting on March 18 at the KSMA Headquarters Office.

Plans were made for the development of a limited

museum, using only the most carefully selected of appropriate items.

One of the functions of the Commission is to provide the financing of the furnishings of the Board Room of the Headquarters Office. It is pleased to report that already twenty-three of the chairs at $75 a chair have been assigned. The contributor's name, on a small, uniform plaque, will be placed on the back of each chair.

The Commission has contacted the past presidents and some of the families of the late past presidents and offered them an opportunity to contribute $100 each to the President's Office-Museum. Already, $1,000 has been collected. These funds are being held in a separate account for use in furnishing the museum.

Your chairman would like to express his appreciation to the members of the Commission for their interest and assistance.

MEMORIALS COMMISSION
G. Y. Graves, M.D., Bowling Green
Francis Massie, M.D., Lexington
Carlisle Morse, M.D., Louisville
Wyatt Norvell, M.D., New Castle
J. Duffy Hancock, M.D., Louisville, Chairman

Recommendations, Reference Committee No. 7

Reference Committee No. 7 has noted the efforts and success of the Memorials Commission and feels that they should be commended for their efforts.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded and it carried.)

Report of KSMA Representative to Conference of Presidents and Other Officers of State Medical Associations

A large attendance was on hand when the Twentieth Annual Meeting of the Conference was called to order by President J. Lafe Ludwig in the Gold Room of the Fairmont Hotel in San Francisco. Doctor Ludwig introduced the president-elect, Raymond McKeown, M.D., who gave a stimulating talk on "Strength in Unity."

Very fine presentations were made by two California candidates for the United States Congress.

Mr. Allan B. Kline, past president of the American Farm Bureau, made an excellent speech on "What Price Freedom," and "Prerequisites for Political Health" was the title of a presentation by the former dean of Law School at Notre Dame University, Clarence E. Manion, J.D. These presentations were well received and were regarded as highly profitable.

George P. Archer, M.D., President
Kentucky State Medical Association

Recommendations, Reference Committee No. 7

Reference Commottee No. 7 recommends that the House of Delegates express its appreciation to our President for attending this meeting.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried.)

Report of KSMA Representative, University of Kentucky Chapter, Student AMA

Our local SAMA organization is beginning to shape up with the first four years having been an ordeal. I had several prolonged telephone conversations with some of the more ardent members and thereafter attended the final meeting of the year, at which time election of officers and a platform of activities was drawn up. The concluding session of the year was an all Medical School dance which was a resounding success.

It is believed that the chapter now anticipates serving as both an off-spring of the AMA, tending to both academic and social needs of the Medical School as a whole. I think they now understand that in the absence of fraternities and sororities—other student government bodies—that their role is a multilateral one.

I also think that the liaison between men such as myself and the other members of the Fayette County Medical Society has been improved and this will be enlarged upon.

Richard H. Segnitz, M.D., KSMA
Representative to U of K Chapter

Recommendations, Reference Committee No. 7

Our committee recognizes the importance of maintaining personal contacts and establishing liaison between practicing physicians and future doctors of our state, and feels that this relationship will be valuable to all concerned. Our representative to the University of Kentucky Chapter is to be commended for his efforts.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried.)

Report of KSMA Representative, University of Louisville Chapter, Student AMA

The past year has been one of continuing activity for the chapter at this school. They have been quite active and have attended local, regional, and the national SAMA meeting in Chicago in May of 1964.

The students hold monthly meetings during the school year and have worked in close cooperation with Dean Donn Smith in his first year of proprietorship at the school. The general rapport amongst the student body and amongst the profession can be attributed to the active efforts of the boys in the SAMA chapter and again one cannot fail to be impressed by the interest and enthusiasm that these boys have towards the problems of the private practice of medicine and to their efforts to try to help us. This was again exemplified by the strong stands that they took at the national SAMA meeting, at which time, they again voted against King-Anderson type legislation and again they were vigorous in their support of only bricks and mortars federal aid. Our boys have a record through the years of being in complete agreement with the AMA's House of Delegates in all of these matters and again they were most instrumental in committee meetings in supporting these just causes.

It was again a pleasure to have the opportunity and privilege of seeing the younger generations of medicine continuing to step into the arena and contribute their part.

Hoyt D. Gardner, M.D., KSMA
Representative to U of L Chapter

Recommendations, Reference Committee No. 7

Again our committee recognizes with approval the efforts of the representative of our association to further the orientation of future doctors to our philosophy and problems, and recommends that he be commended on the success of his efforts.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried.)

Report of KSMA Representative, Advisory Committee on Maternal and Child Health

State Department of Health

The fifth and sixth meetings of the Maternal and Child Health Advisory Committee were held in Louisville and at Kentucky Dam Village. Your KSMA representative was unable to attend but has reviewed the minutes of each meeting very carefully.

Attendance was good at both meetings. A repre-

sentative group of practicing physicians from all sections of the state attended. Holding the committee meetings in different sections of the state seemed to improve attendance. It was agreeded to continue this practice.

At the first meeting in Louisville in January, discussion was given to the continued need for premature and Rh treatment centers in outlying areas. However, due to lack of funds, no progress has been made in this direction. Hospitals in the areas involved are able to take care of the prematures and Rh problems arising in their own hospital but do not have the facilities needed to accept babies born outside the hospital. The University of Kentucky does have a premature nursery with ten beds available which can be used for babies from outside the hospital. This nursery is financed, in part, by the Maternal and Child Health funds. The University of Louisville with the acquisition of additional staff in July may consider establishing such a center also.

Doctor Fraser reported on the plans for Western Pediatric Clinics similar to the Eastern Pediatric Clinics which have been in progress for two years under the direction of the University of Kentucky Center. At present, the Bowling Green clinic is manned by the donated services of Pediatricians in the area. These clinics are confined to indigent patients and the determination of indigency is made locally. Funds are still lacking for hospitalization, laboratory diagnostic work, and for transportation of these indigent patients to Louisville or Lexington as the case may be.

The meeting was closed with a suggestion that the Committee undertake some type of survey to determine the number and types of defective and crippling diseases existing among the children in Kentucky. This will be explored further.

At the sixth meeting at Kentucky Dam Village in April, discussion centered around the need for more Pediatric Clinics in Western Kentucky. A representative group of physicians from throughout Western Kentucky were present. One practicing Pediatrician stated that we could improve on pediatric care in Western Kentucky and stated his experience indicated that private practitioners do not lose a great number of patients to the health department clinics. In fact, quote: "Quite the contrary, as 'all' indigent patients do remain indigent." It was reiterated at this meeting that any clinics established should be kept on a strictly indigent basis. Doctor Fraser asserted that this would be included in the local agreement. Apparently, in most of the clinics, the paying patients are eventually weeded out and only the truly indigent remain. It was stated that the Eastern Kentucky clinics have the complete indorsement of the local medical societies and boards of health. All patients are referred by physicians or in some cases school teachers through physicians.

It would appear to us that as long as such care is maintained on an *indigent basis* and *under local physicians' referral,* it will be a valuable contribution to the health and welfare of our unfortunate children in Kentucky and a step toward lowering the infant mortality rate.

William C. Durham, M.D.
Representative

Recommendations, Reference Committee No. 7

Our committee has studied carefully the detailed report of the studies of this committee, and was impressed with the efforts that are being made to extend treatment centers and clinics in this important field. We feel recognition should be made of the time and talent donated by practicing physicians, especially in the care of indigent cases under local physician's reference.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried.)

Our committee was impressed by the completeness of the reports reflecting the great effort expended in accomplishing the assigned duties by all the committees whose reports it studied.

Mr. Speaker, I move the adoption of the Report of Reference Committee No. 7 as a whole. (The motion was seconded and carried.)

I wish to thank the following members who served on this committee.

Reference Committee No 7
L. F. Beasley, M.D., Franklin, Chairman
Hylan Woodson, M.D., Greenville
Charles E. Peck, M.D., Russell Springs
W. B. Haley, M.D., Paducah
J. M. Stevenson, M.D., Brooksville

Unfinished Business

Doctor Sweeney noted that there was no unfinished business. He expressed appreciation for the spirit of cooperation and the good will of the delegates.

Election of Officers

The Speaker called for the report of the Nominating Committee, which was presented by its chairman, J. Sankey Williams, M.D. Nicholasville. Doctor Williams read the following list of nominations for the positions to be filled as follows.

President-Elect	Everett H. Baker, M.D., Louisville
Vice-Presidents	
Central	Robert W. Lykins, M.D., Louisville
Eastern	Harold B. Barton, M.D., Corbin
Western	Kenneth M. Eblen, M.D., Henderson
AMA Delegate	J. Thomas Giannini, M.D., Louisville
AMA Alternate Delegate	Charles G. Bryant, M.D., Louisville

After each nomination was presented, the Speaker called for nominations from the floor. The only nomination received from the floor was the name of B. H. Warren, M.D., Owensboro, for the office of Western Vice President. For each office other than the office of Western Vice President, each nominee was elected individually without dissent. The tellers counted the ballots for the contested office and Kenneth M. Eblen, M.D., Henderson, was declared elected vice president from the western district.

Doctor Williams then submitted the following nominations to the office of trustee:

Second District	W. Gerald Edds, M.D., Calhoun
Seventh District	Donald Chatham, M.D., Shelbyville
Ninth District	Mitchel B. Denham, M.D., Maysville
Tenth District	Douglas E. Scott, M.D., Lexington
Thirteenth District	Walter L. Cawood, M.D., Ashland

The same procedure followed in electing the general officers was followed in the election of the trustees. Since there were no nominations from the floor, the above-named nominees were elected.

Doctor Baker, the new President-Elect, was escorted to the rostrum. He received a standing ovation.

Nominations for Board of Directors, Kentucky Physicians Mutual, Inc.

The following list of nominees for the Board of Directors, Kentucky Physicians Mutual, Inc., was submitted and received for information only:

George P. Archer, M.D., Prestonsburg
Branham B. Baughman, M.D., Frankfort
Charles J. Bisig, M.D., Louisville
A. L. Cooper, M.D., Somerset
G. Y. Graves, M.D., Bowling Green
William W. Hall, M.D., Owensboro
O. Leon Higdon, M.D., Paducah
C. Charles Hugan, Jr., M.D., Covington
Max D. Klein, M.D., Shelbyville
W. K. Massie, M.D., Lexington
Carlisle Morse, M.D., Louisville
Earl P. Oliver, M.D., Scottsville
George W. Pedigo, Jr., M.D., Louisville
W. Vinson Pierce, M.D., Covington
R. W. Robertson, M.D., Paducah
Charles C. Rutledge, M.D., Hazard
Fred A. Scott, M.D., Madisonville
Charles B. Stacy, M.D., Pineville
Russell E. Teague, M.D., Frankfort
Leslie H. Winans, M.D., Ashland

Election of 1964 Nominating Committee

The nominating committee to serve at the 1965 Annual Meeting was elected as follows:

Harold B. Barton, M.D., Corbin
Carl H. Fortune, M.D., Lexington
Russell L. Hall., M.D., Prestonsburg
James M. Riley, Jr., M.D., Louisville
Paul J. Sides, M.D., Lancaster

Delmas M. Clardy, M.D., Hopkinsville was installed as president. The oath of office was administered by the Chairman of the Board of Trustees, Douglas E. Scott, M.D. President Clardy presented the past president's key to the retiring president, George P. Archer, M.D., Prestonsburg.

In his inaugural remarks, the new president discussed the KMA oath of office as is currently written and offered some thoughts on how it might be appropriately revised.

Doctor Sweeney thanked the members of the House of Delegates for their cooperation during both sessions. The second session of the 1964 House of Delegates was adjourned at 11:15 p.m.

ORGANIZATION SECTION

1965 KMA Interim Meeting Set For March 18 at Owensboro

Plans for the 1965 KMA Interim Meeting, to be held in Owensboro on Thursday, March 18, are virtually complete, Delmas M. Clardy, M.D., KMA president and chairman of the Interim Meeting Program Committee, has reported.

Following the meeting of the Program Committee in Owensboro on November 19, Doctor Clardy announced that excellent speakers of national stature had been or were being committed for the meeting.

Austin Smith, M.D., president of the Pharmaceutical Manufacturers' Association and former editor of the Journal of the American Medical Association, whose speaking talents are in universal demand, will be featured as the luncheon speaker.

Important topics to be covered at the meeting include comments on the situation in Washington, new developments in prepayment, medicine's interest in area-wide hospital planning, and improvement in relations with allied groups.

Doctor Clardy said that full details will appear in subsequent issues of The Journal. The meeting will be held at Gabe's Restaurant and Motor Inn at Owensboro, and suggested that early reservations be made.

Fifth District to Meet Jointly With Fourth and Seventh

The Fifth Trustee District will play host to members of the adjoining Fourth and Seventh Districts at an important and informative meeting December 17 at the Medical Arts Building in Louisville, according to Alfred O. Miller, M.D., Louisville, Fifth District Trustee, who is in charge of arrangements.

Doctor Weston

Jean K. Weston, M.D., director of the department of drugs of the American Medical Association, will be the featured speaker of the evening. Sharing the spotlight with Doctor Weston will be Delmas M. Clardy, M.D., Hopkinsville, president of KMA, who will speak on the topic, "Your State Association."

Doctor Weston will present a discussion of the AMA's new drug testing program and the many ways in which the program will protect the public and serve the medical profession. He holds a Ph.D. degree from the University of Michigan and an M.D. degree from Temple.

A former laboratory director in experimental pathology and toxicology and former director of the department of clinical investigation for Parke, Davis and Company, Doctor Weston has also served as director of medical affairs for Burroughs Wellcome and Company.

Ky. Physicians' Mutual Board Elects Dr. Rust President

Richard J. Rust, M.D., Newport, was elected president of the Board of directors of Kentucky Physicians' Mutual (Blue Shield Plans in Kentucky) at the annual meeting of the Board on November 5 in Louisville.

Doctor Rust

Doctor Rust, a surgeon, was for many years chairman of the Medical Advisory Committee to the Board of Kentucky Physicians' Mutual and was one of the early members of the Board. He has held numerous committee appointments within KMA and has been active in the medical and civic affairs of his community.

Garnett J. Sweeney, M.D., Liberty, speaker of the KMA House of Delegates, and Robert W. Robertson, M.D., Paducah, past president of KMA, were elected vice-presidents of the Board at the November 5 meeting. B. B. Baughman, M.D., Frankfort, a member of the State Board of Health, was re-elected treasurer.

J. P. Sanford, Louisville, executive secretary of KMA, was re-elected secretary of the Board, and D. Lane Tynes, Louisville, was re-elected to the post of executive director. Mr. Tynes is executive director of Blue Shield and president of Blue Cross.

A readership questionnaire designed to gather significant opinions from you, our readers and members, about your KMA Journal, will be published in the January, 1965 issue of The Journal. An evaluation of your likes and dislikes will be of great value to us in formulating plans for the future. You are urged to watch for this questionnaire in The January Journal and to voice your opinion at that time.

The Editors

Ky. Assn. of Registered Nurses Elects Mrs. Nadine Turner

Mrs. Nadine Turner, director of nursing at the Murray-Calloway County Hospital, was elected president of the Kentucky State Association of Registered Nurses at the 1964 annual meeting of the Association in Louisville October 14-16.

Mrs. Turner

Mrs. Turner, who received her nursing degree from Norton Memorial Infirmary in Louisville, also holds a B.S. Degree in nursing from Vanderbilt University School of Nursing in Nashville.

Among the highlights of her nursing career have been posts at nursing schools in Texas, Illinois, and Kentucky. Mrs. Turner was director of nursing at Muhlenberg Community Hospital in Greenville before going to Murray.

Also elected at the October meeting of the association were the following new officers: Mrs. Kathryn Koon, Hopkinsville, second vice-president; Miss Lillian Shacklette, Louisville, treasurer; and Miss Agnes C. Hinman, Lexington and Sister Agnes Miriam, Louisville, directors.

Ky. Pair Take Part In Congress On Mental Health at Chicago

Beverly T. Mead, M.D., Lexington, assistant professor of psychiatry at the University of Kentucky Medical Center, and Robert G. Cox, KMA executive assistant, had key roles in the AMA Second National Mental Health Congress in Chicago November 5-7.

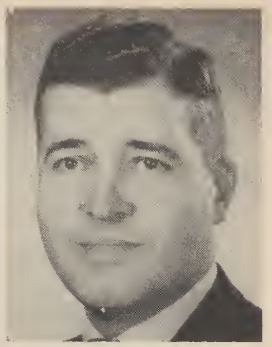
Doctor Mead was co-chairman of a workshop session concerning the enlistment of community support in rural areas.

Mr. Cox addressed participants in two workshops. His subjects were, "The Role of the County and State Medical Society in the Mental Health Movement", and "The Role of the Private Practitioner in Mental Health in Rural Areas".

Correction

The Journal regrets an unfortunate error in the Case Discussion heading on page 871 of the November issue. The discussion, entitled "Eclampsia: A Case Report", by John L. Duhring, M.D., and Donald Edger, M.D., both of the University of Kentucky College of Medicine, originated at the U.K. Medical Center, and *not* from the University of Louisville, as stated in the headline.

Doctor Harbison



Doctor Seeley

Norton Postgraduate Seminar Set Dec. 17 in Louisville

An excellent scientific postgraduate program, featuring two outstanding guest speakers, has been planned for the Seventh Annual Norton Memorial Infirmary Seminar December 17, according to Robert Lich, Jr., M.D., program chairman. The Seminar, to be held at Norton, will be co-sponsored by the Kentucky Academy of General Practice.*

Samuel T. Harbison, M.D., professor of surgery and associate dean of the University of Pittsburgh School of Medicine, will read papers on "Routinism, Iatrogenics and Surgical Care", and "An Evaluation of Recent Surgical Thinking".

William C. Sheldon, M.D., of the department of pediatric cardiology and the cardiac laboratory at Cleveland Clinic will provide another highlight of the program with two motion pictures, "The Cine Cardioangiography of Acquired Valve Disease", and "Cine Coronary Arteriography", Doctor Lich said.

E. C. Seeley, M.D., London, president of the KAGP, and Ludwig H. Segerberg, M.D., president of the Norton medical staff, will serve as presiding officers of the day-long program. The Seminar will also feature the presentation of nine other papers by faculty members of the University of Louisville School of Medicine.

Primarily directed toward the physicians of the Kentucky and Southern Indiana areas, the Seminar is open to all physicians who care to attend.

**Category I Credit applied for.*

Perry County Report is First

The Perry County Medical Society has the distinction of being the first County Society to report its 1965 officers roster to the Kentucky Medical Association. The report was sent by Charles C. Rutledge, M.D., Hazard, secretary.

Ralph Westervelt, M.D., will serve the society as president for the coming year. Also named were John F. Gilbert, M.D., vice-president; E. S. Carter, M.D., delegate to KMA; and Mary Pauline Fox, M.D., alternate delegate. Doctor Rutledge will serve as secretary and treasurer. He is also an alternate delegate from KMA to the AMA. The Perry County officers, all from Hazard, will take office January 1.

Dr. Cotthoff Elected Chairman of Ky. Rural Health Council

John E. Cotthoff, M.D., Hopkinsville, was elected chairman of the Kentucky Rural Health Council at a Council meeting following the Kentucky Rural Health Conference at the University of Kentucky Medical Center October 22.

"Health Careers" was the theme of the 12th annual conference, sponsored by the Rural Health Council. Delmas M. Clardy, M.D., Hopkinsville, president of KMA, was featured on the program, bringing greetings from the Kentucky Medical Association.

William R. Willard, M.D., dean of the U.K. College of Medicine and vice-president for the Medical Center, presented a thought-provoking talk on employment needs in the health field. Also on the program was Samuel Evans, Kentucky community employment program supervisor, who spoke on the employment and manpower situation in Kentucky.

Miss Deanna McLean, Kentucky Dairy Princess from Little Mount in Spencer County, served milk to the group during a break in the program. Miss McLean represented the American Dairy Association in Kentucky.

Robert L. Johnson, director of State and Local Services for the U.K. Medical Center, who served as program chairman for the Conference, was elected vice-chairman of the Council. William Padon, of the Kentucky Farm Bureau Federation, was re-elected secretary.

Ky. Medical Assistants Attend National Meeting Oct. 13-18

Seven representatives of the Kentucky State Association of Medical Assistants attended the eighth annual meeting of the American Association of Medical Assistants in Oklahoma City October 13-18, according to Miss Dorothy Downs, Louisville, KSAMA president and a delegate to the national meeting.

Attending with Miss Downs were delegates Mrs. Phoebe Faust and Mrs. Wanda Taylor, both of Louisville, and four alternate delegates: Mrs. Ernestine Gates, Mrs. Louise Hawkins, Miss Libby Curtsinger, and Mrs. Virginia Applegate, president of the Jefferson County Medical Assistants.

At its House of Delegates meetings the AAMA pledged organizational support and assistance to the American Medical Association in all legislative matters pertaining to the practice of medicine as a free enterprise. The House also went on record as endorsing the objectives of the American Medical Political Action Committee. The meeting had a record registration of 488.

New AMA Field Representative For Ky. is State Native

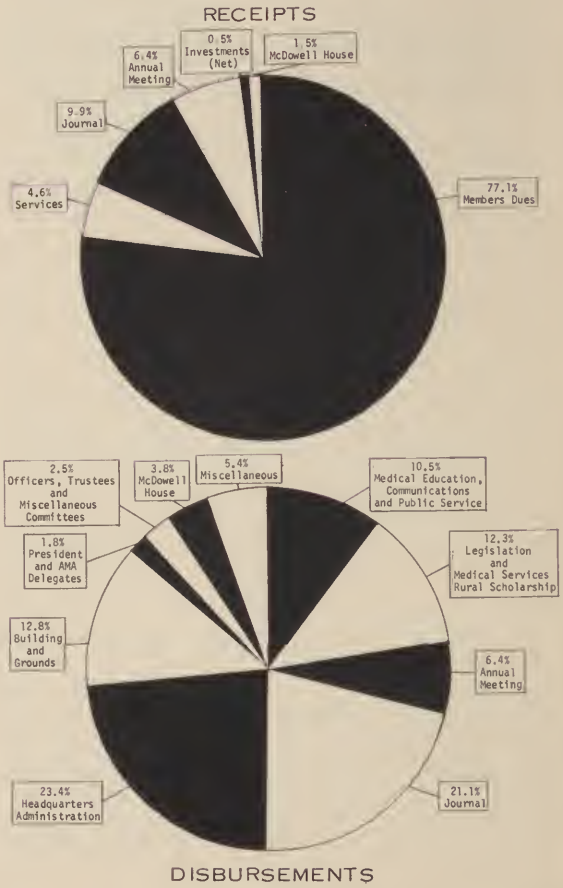
Harry R. Hinton, Chicago, a native Kentuckian and former administrator of Hazelwood Sanitorium in Louisville, has been assigned to cover Kentucky as field representative for the American Medical Association, Aubrey D. Gates, director of the AMA Division of Field Service, announced recently.

William R. Ramsey, who held this post for the past several years, has been named assistant director of the Division of Field Service. Mr. Hinton, who took over the Kentucky assignment November 1, will also cover Ohio, Pennsylvania, and West Virginia.

Mr. Hinton, a native of Sturgis, is known to a number of Kentucky physicians through his work in the Kentucky Junior Chamber of Commerce while in Louisville, and as administrator of Hazelwood.

Graphs Depict Distribution Of KMA Finances

Sources of income and the way its funds are disbursed by KMA are shown on the pie-shaped graphs below. These graphs, prepared by the Association's auditors, are based on the 1963-64 fiscal year. If members have any questions, they are urged to contact the headquarters office.



The Doctor's Visit, Jan Steen 1626-1679, Mauritshuis, The Hague

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METAMUCIL® brand of psyllium hydrophilic mucilloid

"Diverticulosis ... a low-roughage diet is advisable.... Constipation is avoided, preferably by the daily use of Metamucil.

"Diverticulitis Mild, chronic symptoms of diverticulitis, such as diarrhea or flatulence also are treated[1] by low-roughage diet, adequate fluid intake and Metamucil...."

Usual Adult Dosage: One rounded teaspoonful of Metamucil (or one packet of Instant Mix Metamucil) in a glass of cool liquid one to three times daily.

Metamucil is available as Metamucil powder in containers of 4, 8 and 16 ounces and as flavored Instant Mix Metamucil in cartons containing 16 and 30 single-dose packets.

1. Welch, C. E., Diverticula of the Alimentary Tract, in Conn, H. (editor): Current Therapy—1961, Philadelphia, W. B. Saunders Company, 1961, pp. 224-225.

SEARLE

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A 15 mm. Hg drop in diastolic pressure would also suit her very well

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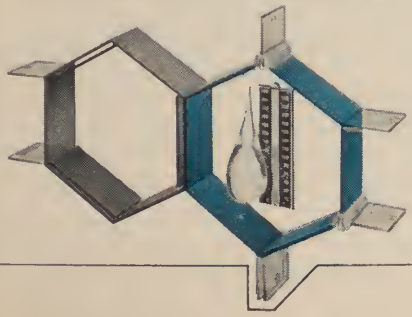

HYDROMOX Quinethazone is excellent for use in early hypertension. Extremely well tolerated, the average reported reduction in diastolic pressure is 15 mm. Hg,[1,2] just right for patients with mild to moderate diastolic elevations. Systolic pressure lowered accordingly. A convenient, single daily dose of one to two 50 mg. tablets is usually sufficient.

INDICATED in hypertension with or without edema, and in all types of edema involving salt retention. May be helpful in some cases of lymphedema, idiopathic edema and edema due to venous obstruction.

SIDE EFFECTS: Skin rash (rare), gastrointestinal disturbances, weakness and dizziness, seldom so severe that drug should be stopped. Generally, the adverse effects sometimes associated with the thiazide diuretics are possible. Pre-existing electrolyte abnormalities may be aggravated.

CONTRAINDICATION: Anuria.

1. Steigmann, F., and Griffin, R.: Evaluation of Quinethazone, a New Diuretic. J. Amer. Geriat. Soc. 11:945 (Oct.) 1963.

2. Schwartz, M.: Office Evaluation of a New Diuretic in Patients with Hypertensive Diseases. Scientific Exhibit Presented at the Clinical Meeting of the American Medical Association, Los Angeles, California, Nov. 25-28, 1962.

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Medical School News

U.L. Accepts Gifts and Grants of $282,582 for Med. School

In a recent meeting the University of Louisville Board of Trustees voted to accept gifts and grants to the School of Medicine totaling $282,582 for research, scholarships, and other areas of need.

Following are a list of the recipients, amount of grant or gift, and the donor:

Steven Vandenburg, M.D., $82,365; Jose A. Zadunaisky, M.D., $24,561; Ulrich Westphal, Ph.D., $20,492; Kenneth McConnell, M.D., $18,764; K. C. Huang, M.D., $17,733; Frederick Hilton, M.D., $17,-251; Joseph Gennaro, M.D., $16,813; James Rogers, M.D., $11,138; and Frank Falkner, M.D., $6,465—a total of $215,582. all from the U.S. Public Health Service.

C. Dwight Townes, M.D., received a $25,500 grant from Research to prevent Blindness; Robert J. Kaiser, M.D., $3,300 from the National Society for Prevention of Blindness; and $3,000 to Leonard Berman, M.D., from Lloyd Brothers pharmaceutical manufacturers.

The new radiation center operated by the department of radiology received $20,000 from the Kentucky Division of the American Cancer Society; and the department of medicine was given a $6,000 grant-in-aid by Ayerst Laboratories; Commonwealth Life Insurance Company gave $3,500 for research in allergy and immunology.

Mrs. Dann C. Byck of Louisville gave the department of pediatrics 24 shares of Sears, Roebuck and Company common stock to continue the Dann C. Byck Fellowship in Pediatrics. An anonymous donor contributed $500 to establish an annual prize in pharmacology in the School of Medicine.

Faculty Appointments and Changes

The Board of Trustees at the October meeting also approved the following changes and appointments among School of Medicine faculty members:

Appointment of Bernard Schneider, M.D., as clinical instructor of obstetrics and gynecology; appointment of William Woodward Nicholson, M.D., as professor emeritus of pediatrics; promotion of Dorothy Shipe, Ph.D., to assistant professor of pediatrics; and promotions of Maurice T. Fliegelman, M.D., and Paul Mapother, M.D., to associate clinical professors of dermatology in the department of medicine.

Additional appointments were listed for the following:

Angelo A. Ciliberti, assistant professor of medicine, as associate in microbiology; Leonard B. Berman, M.D., associate professor of medicine, as associate in physiology; Jose A. Zadunaisky, M.D., associate professor of ophthalmology, as associate in physiology. The Board also voted tenure for Gaspar Carrasquer, M.D., associate professor of medicine and associate in physiology.

U.K. Med. Center Names New Orthopedic Surgery Chief

Thomas D. Brower, M.D., has been named new professor and chief of the section of orthopedic surgery at the University of Kentucky Medical Center, according to a recent announcement.

Doctor Brower, who graduated in 1947 from the Washington University School of Medicine in St. Louis, was associate professor of orthopedic surgery at the University of Pittsburgh School of Medicine before coming to Lexington.

Peter P. Bosomworth, M.D., chairman of the U.K. department of anesthesiology, and Lester R. Bryant, M.D., associate professor of surgery, presented a paper on "Physiologic Responses to Aspiration of Gastric Juices" at the 1964 annual meeting of the American Society of Anesthesiologists at Bal Harbour, Fla., October 12.

Cell Biology Department Approved

Establishment of a department of cell biology in the University of Kentucky medical and dental colleges was recently approved by the U.K. Board of Trustees. Richard S. Schweet, Ph.D., was named chairman of the department.

A dormitory for nursing students was dedicated October 25 at the University of Kentucky Southeastern Center at Cumberland, where young women participating in the Appalachian Regional Hospitals' professional nursing program will study for one year before completing the three-year course at the ARH Nursing School in Harlan. The school is operated by the Harlan ARH Hospital.

Dr. Simpson Honored

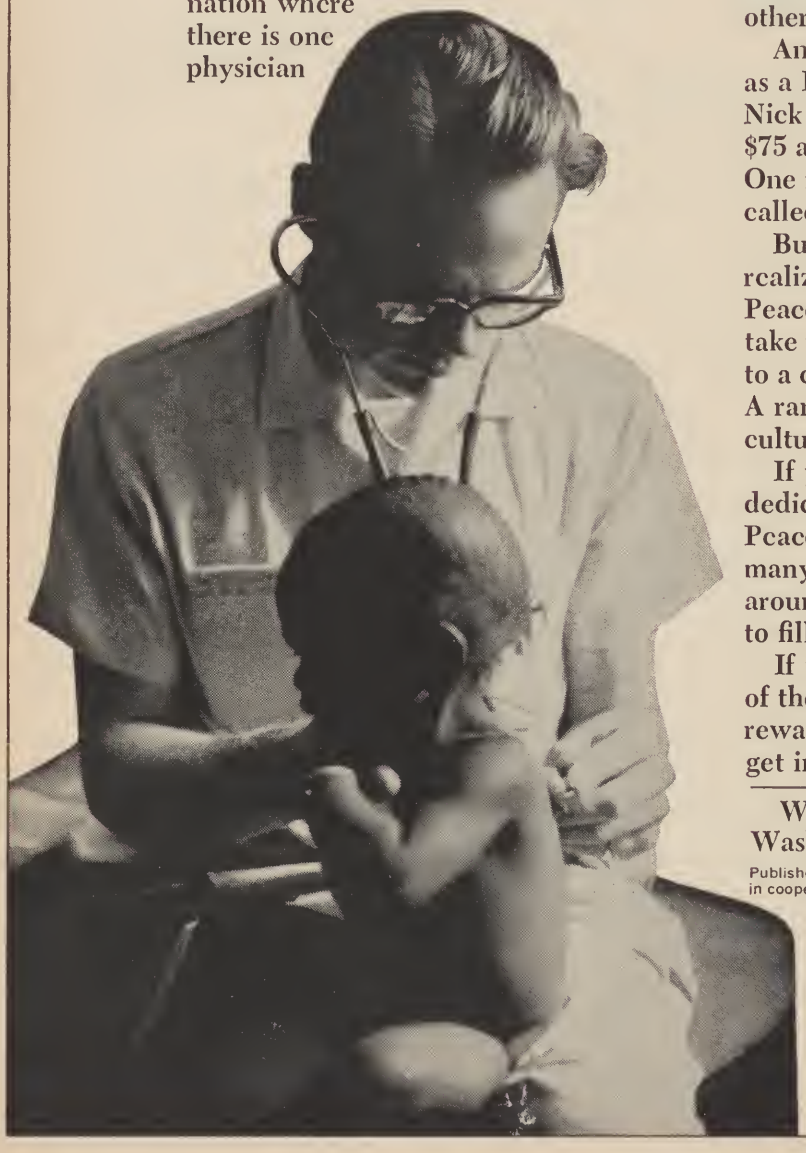
Gaithel L. Simpson, M.D., Greenville, past president of KMA, received the Conservation Award of Merit at the fourth annual Conservation Congress in Louisville in October. The awards are presented annually for outstanding work in promoting good conservation practices. Doctor Simpson is chairman of the Pond River Conservation District. KMA awarded Doctor Simpson its Distinguished Service Medal in 1964.

"My colleagues thought I was crazy!"

Nick Cunningham, M.D., was eminently qualified for any number of promising medical posts here at home. Harvard pre-med. Hopkins medical. London's Guys Hospital. New York's Presbyterian Hospital.

Yet, with this rich professional background, Nick Cunningham chose to become one of the first volunteer doctors in the Peace Corps.

He preferred to go to an African nation where there is one physician



for every 80,000 people. Where modern medicine is all but unknown. Where the most stubborn clinical problems exist. Cholera, trachoma, encephalitis, leprosy and a horde of other debilitating diseases.

And for his two-year stretch as a Peace Corps doctor, Nick Cunningham's pay was only $75 a month — plus living expenses. One reason why his colleagues called him crazy.

But Dr. Cunningham saw and realized other compensations in his Peace Corps assignment. A chance to take the best in American medicine to a country desperately needing it. A rare opportunity for professional, cultural and personal growth.

If you've some of the spirit and dedication of Nick Cunningham, the Peace Corps needs you. There are many more requests from nations around the world than doctors to fill them.

If you think you could tackle one of the most challenging and rewarding openings in medicine today, get in touch with us.

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McDOWELL HOUSE VISITORS, representatives of the Cincinnati Medical History Society, are shown in the living room of the famous old home in Danville, which they visited October 15. From left are Cecil Striker, M.D., president of the Society; Mrs. Striker; Julien Benjamin, M.D.; George Grider, Danville, curator of the McDowell House; and John Braunstein, M.D.

Cincinnati Medical Historians Tour McDowell House

Boyle County Medical Society members and their wives played host October 15 to wives and members of the Cincinnati Medical History Society at McDowell House in Danville, where the group climaxed a tour of central Kentucky medical/historical sites.

The Cincinnatians, headed by Cecil Striker, M.D., president of the Society, were entertained at a tea in the McDowell Home by local physicians and Medical Auxiliary members. Also on hand for the event were Miss Estelle Crawford, official hostess of McDowell House, and George Grider, Danville pharmacist and curator of the House and Shop.

Among other spots on the History Society's tour program were Transylvania College Library at Lexington, where the McDowell collection is housed, and the John Hunt Morgan House in Lexington.

U. of L. Sets Ten-Week Course Electrocardiography

A ten-week Postgraduate Course in Electrocardiographic Interpretation is scheduled to open Wednesday night, January 6, 1965 at the Louisville General Hospital under the sponsorship of the University of Louisville Medical Center. The sessions will be held from 7 to 9 p.m. each Wednesday through March 10.

The fee for practicing physicians is $35.00. Preliminary registration should be directed to the Dean's Office, University of Louisville School of Medicine. The course has been submitted to the Kentucky Chapter of the American Academy of General Practice for Category I credit.

Speakers for the course, all from the University of Louisville School of Medicine, are Maurice Best, M.D., Associate Professor of Medicine; Herbert L. Clay, M.D., Associate Professor of Medicine; Walter S. Coe, M.D., Associate Clinical Professor of Medicine; Ralph Denham, M.D., Instructor in Medicine; Charles H. Duncan, M.D., Associate Professor of Medicine; and

Topics for the course have been announced as follows:

January 6: "Introduction, Theory and Basic Principles of Electrocardiography"; Dr. Clay and Dr. Best.

January 13, 20 and 27: "Development of Simple Vectoral Analysis Method of Interpretation and Slide Demonstrations"; Dr. Clay and Dr. Best.

February 3: "Review of Vectoral analysis Method and Discussion of Digitalis Effect with Slide Demonstrations"; Dr. Clay and Dr. Coe.

February 10: "Sinus Rhythm Disturbances and Ectopics" and "Av Conduction Defects"; Dr. Denham and Dr. Coe.

February 17: "Atrial and Nodal Rhythm Disturbances" and I.V. Conduction Defects"; Dr. Denham and Dr. Coe.

February 24: "Ventricular Rhythm Disturbances" and "Quinidine, Potassium and Calcium Effects and Electrocardiogram"; Dr. Denham and Dr. Best.

March 3: "Effects of Exercise on Electrocardiogram" and "Effects of Emotional States on Electrocardiogram"; Dr. Denham and Dr. Duncan.

March 10: "Review"; all speakers.

Jeff. Society Honors 21

The Jefferson County Medical Society at its November 16 meeting honored 21 former presidents, six of whom have also been presidents of the Kentucky Medical Association. Each of the group was presented with an engraved gavel at special ceremonies during the regular meeting at the Medical Arts Building.

NEWS ITEMS

Larry B. Craycraft, M.D., and **Dorval H. Donahoe, M.D.,** have announced the opening of their office in Catlettsburg, where they will have a general practice. Both are 1963 graduates of the West Virginia University College of Medicine and both interned at Mercy Hospital in Springfield. Doctor Donahoe and Doctor Craycraft are natives of West Virginia.

Francis J. Dillard, M.D., has become associated with the Fuller-Morgan Clinic at Mayfield, it was recently announced. An internist, Doctor Dillard graduated in 1949 from the Medical College of Virginia and interned the following year at Geisinger Memorial Hospital at Danville, Pa. He was a resident at the Veterans Administration Hospital in Richmond.

Thomas F. Plaut, M.D., Whitesburg, a 1959 graduate of Columbia University College of Physicians and Surgeons, has become associated with the Daniel Boone Clinic, it was recently announced. Doctor Plaut, a pediatrician, interned in pediatrics at Bellevue Hospital, New York City, and completed his residency at the same hospital.

James V. Grief, M.D., Covington, has become associated with **Maurice R. Walsh, M.D., Norman Adair, M.D., Morris M. Garrett, M.D.,** and **W. Donald Janney, M.D.,** at Covington, for the practice of radiology. Doctor Grief, a 1960 graduate of Indiana University School of Medicine, interned at Polk County Hospital, Des Moines, Iowa, and completed his residency at the Indiana University Hospital.

Robert E. Robbins, M.D., has started practice at Greenville in the offices of **Gaithel L. Simpson, M.D.,** and **George H. Rodman, M.D.** A surgeon, Doctor Robbins graduated in 1958 from the University of Cincinnati College of Medicine and interned at St. Mary's Hospital in Cincinnati. His residency requirements were completed at the University of Louisville hospitals.

Clyde T. Moore, M.D., and **Robert J. Lehman, M.D.,** both of Louisville, were elected in the November 3 general election to terms on the Boards of Education of Louisville and Jefferson County. Doctor Moore was reelected for his second four-year term on the Jefferson County Board, and Doctor Lehman was newly elected for four years on the City Board.

Wellington B. Stewart, M.D., professor and chairman of the department of pathology at the University of Kentucky Medical Center, has been named chairman of the Board of Registry of Medical Technologists of the American Society of Clinical Pathologists.

Paul C. Grider, Jr., M.D., Louisville, is now associated with **George W. Pedigo, M.D.,** for the practice of internal medicine. Before completing his internship and residency at Parkland Memorial Hospital in Dallas, Doctor Grider graduated in 1958 from the University of Louisville School of Medicine.

M. C. Blaydes, M.D., Lexington, is practicing internal medicine in association with the Lexington Clinic, it was recently announced. Doctor Blaydes, who graduated in 1954 from the University of Virginia College of Medicine, interned at Strong Memorial Hospital, Rochester, New York, and was a resident there and at the University of Virginia Hospital.

Lewis E. Martin, M.D., has started general practice at Adairville, according to recent announcement. He is a 1963 graduate of the University of Louisville School of Medicine, and interned at Mercy Hospital in Springfield, Ohio. Doctor Martin previously practiced for a short time at Cadiz.

John F. Gilbert, M.D., Hazard, has announced the opening of his office in that city, where he will practice general medicine. Doctor Gilbert graduated from the University of Louisville School of Medicine in 1963 and interned at the University of Kentucky Medical Center.

County Society Reports

McCracken

F. Y. Clare, M.D., Louisville, presented the scientific program on the subject of "Eradication Program for Syphilis in the United States" at the September 23 meeting of the McCracken County Medical Society at Boswell's restaurant in Paducah. O. D. Maxey, M.D., Paducah, president, presided at the meeting.

A letter was read regarding the establishment of a sheltered workshop for the mentally retarded and handicapped adults in the Paducah area. A donation of any size was requested. It was pointed out that the balance of money left over from the polio drive was donated for this purpose.

Society participation in the nation-wide educational program sponsored by the AMA was discussed and agreed upon.

The Board of Censors accepted and approved the applications of two new members.

The Society went on record as approving the sewerage program for the city.

The meeting adjourned at 9:10 p.m.

McCracken

M. Edward Davis, M.D., professor of obstetrics and gynecology at the Chicago Lying-In Hospital, was our distinguished guest for the October 28 meeting of the McCracken County Society held at Boswell's Restaurant. O. D. Maxey, M.D., Paducah, president, presided at the meeting.

Doctor Davis presented the scientific program for the evening on the topic, "Estrogens and Retardation of Aging in Women."

The Society voted to extend an invitation to all regular meetings to all members of the First Trustee District. This is to be done on a routine basis.

A nominating committee was appointed by Doctor Maxey to propose a slate of officers at the December meeting. The meeting adjourned at 9:25 p.m.

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Continuing Educational Opportunities

From The

KMA Postgraduate Medical Education Office

IN KENTUCKY

DECEMBER

17 — 7th Annual Post Graduate Medical Seminar, Sponsored by Norton Memorial Infirmary & Kentucky Chapter American Academy of General Practice, Norton Memorial Infirmary, Louisville

17 — University Surgery Day, 12:00-5:00 p.m., University of Kentucky Medical Center, Lexington

17 — KMA Joint Trustee District Meeting, 4th, 5th and 7th Districts, Dinner Meeting, Medical Arts Building, Louisville

JANUARY

7 — "Professor's Day", 9:00 a.m. to 3:00 p.m., University of Kentucky Medical Center, Lexington

6, 13, 20, 27 — "Electrocardiographic Interpretation": 7:00 p.m. - 9:00 p.m. (Wednesday evenings), University of Louisville Medical Center, Louisville

14 — Pediatrics, "Refresher Course", 8:00 a.m.- 5:00 p.m., University of Kentucky Medical Center, Lexington

21 — University Surgery Day, 12:00-5:00 p.m., University of Kentucky Medical Center, Lexington

29 — "Cardiology Night": 7:30 p.m. - 9:00 p.m., University of Kentucky Medical Center, Lexington

FEBRUARY

3, 10, 17, 24 — "Electrocardiographic Interpretation": 7:00 p.m. - 9:00 p.m., (Wednesday evenings), University of Louisville Medical Center, Louisville

4 — "Professor's Day": 9:00 a.m. - 3:00 p.m., University of Kentucky Medical Center, Lexington

11 — Pediatrics, "Refresher Course": 8:00 a.m. - 5:00 p.m., University of Kentucky Medical Center, Lexington

18 — Medicine, "G. I. Diseases": 8:00 a.m. to 5:00 p.m., University of Kentucky Medical Center, Lexington

26 — "Cardiology Night": 7:30 p.m. - 9:00 p.m., University of Kentucky Medical Center, Lexington

MARCH

3 — "Electrocardiographic Interpretation": 7:00 p.m. - 9:00 p.m., (Wednesday evenings), University of Louisville Medical Center, Louisville

11 — Pediatrics, "Refresher Course": 8:00 a.m.- 5:00 p.m., University of Kentucky Medical Center, Lexington

11-12 — Hematology, University of Kentucky Medical Center, Lexington

18 — KMA Interim Meeting, Gabe's Motor Inn, Owensboro, Kentucky

26 — "Cardiology Night": 7:30 p.m. - 9:00 p.m., University of Kentucky Medical Center, Lexington

29-30 — Symposium on Genito-Urinary Disease, University of Kentucky Medical Center, Lexington

IN SURROUNDING STATES

JANUARY

9-14 — American Academy of Orthopaedic Surgeons, Americana Hotel, New York, New York

14 — Northern Kentucky Seminar, KAGP, Cincinnati, Ohio

20-22 — *Diabetes in Review: Clinical Conference, 1965,* Drake Hotel, Chicago, Illinois

25-27 — American College of Surgeons, Sectional Meeting, Atlanta Biltmore Hotel, Atlanta, Georgia

25-27 — Society of Thoracic Surgeons, Chase-Park Plaza Hotel, St. Louis

29-31 — Southern Radiological Conference, Grand Hotel, Point Clear, Ala.

FEBRUARY

5-10 — Congress on Medical Education, Palmer House, Chicago, Illinois

25-March 2 — American Dermatological Association, Boca Raton Hotel, Boca Raton, Florida

Dr. Witten on AMA Committee

As the Journal went to press it was learned that Carroll L. Witten, M.D., Louisville, delegate to the American Medical Association from the Section on General Practice, had been appointed to serve on the Reference Committee on Medical Education and Hospitals at the AMA interim meeting in Miami Beach November 29-December 2. The appointment was made by Milford O. Rouse, M.D., Dallas, speaker of the AMA House of Delegates.

Daviess County M.D.s Honored

Five Daviess County physicians were awarded silver loving cups at the October 27 meeting of the Daviess County Medical Society for their services rendered for the Daviess County Board of Public Health.

The Board honored William W. Hall, M.D., president of the Daviess County Medical Society; Anne Hopwood, M.D., county Health Officer; Thomas H. Milton, former Board member; W. H. Parker, M.D., former Health Officer; and William L. Woolfolk, M.D., former Board member. All are from Owensboro.

Retardation Unit Gets Director

JoAnne Sexton, M.D., Louisville, has been named to head the Mental Retardation Program of the Kentucky State Department of Health, according to a recent announcement by Helen B. Fraser, M.D., director of the division of Maternal and Child Health of the Department of Health.

Doctor Sexton, a pediatrician, will work with the Department of Health and the University of Louisville School of Medicine in carrying out the program. She is a 1957 graduate of the U. of L. School of Medicine and completed her residency at Children's Hospital. She also completed a one-year fellowship in pediatric neurology at Baylor University in Houston.

New National Society Formed

The American Academy of Facial Plastic and Reconstructive Surgery, Inc., was formed in Chicago October 18 through the merger of the American Otorhinologic Society for Plastic Surgery, Inc., and the American Society of Facial Plastic Surgery, Inc. The merger was approved by the membership of both groups.

The new medical society, expected to include approximately 700 physicians, will consist mainly of otolaryngologists who perform plastic and reconstructive surgery of the head and neck. It was formed with the assistance of the American Medical Association and the American Academy of Ophthalmology and Otolaryngology.

State officers and County presidents and presidents-elect of the KMA Woman's Auxiliary met November 10 in the Board Room of the KMA Headquarters office for their annual Fall Conference and Board of Directors' meeting. Seated from left to right are Mrs. Earl Roles, Louisville, co-editor of the Blue Grass News and a regional vice-president of the AMA Auxiliary; Mrs. John F. Ashworth, Ashland, Boyd County president; Mrs. J. Jack Martin, Tompkinsville, KMA Auxiliary president; Mrs. George P. Archer, Prestonsburg, state program chairman; and Mrs. Robert J. Salisbury, Mt. Sterling, president-elect of the state auxiliary. Herbert L. Clay, Jr., M.D., Louisville, gave an address before the group at the morning session.

Automotive Medical Group Meets

William K. Keller, M.D., Louisville president of the American Association for Automotive Medicine, presided over the 1964 Annual meeting of the association held October 26-27 in Louisville. Doctor Keller, chairman of the department of psychiatry at the U. of L. School of Medicine, completed his one-year term of office this year, and was succeeded by Joseph M. Janes, M.D., of the Mayo Clinic, Rochester, Minn.

Industrial Health Group to Meet

The 1965 American Industrial Health Conference will be held April 5-8 at the Americana Hotel, Miami Beach, Fla., it has been announced by the Industrial Medical Association and the American Association of Industrial Nurses. Further information about the Conference may be obtained by writing to the American Industrial Health Conference, 55 East Washington St., Chicago, Ill., 60602.

Nursing Home Group Elects

William Pierce, Louisville, was elected president of the Kentucky Association of Nursing and Personal Care Homes during the November 10-11 meeting of the group in Paducah.

Named first, second and third vice-presidents, in that order, were: Leon Kingsolver, Danville, Mrs. Mary Metzmeier, Campbellsville, and Alton Foster, Scottsville. Mrs. Helen Piper, Paducah, was elected secretary, and Elmer Schafner, Louisville, treasurer. At the same meeting, Mrs. Ann Stokes, Louisville, was installed as fourth regional vice-president of the national association.

From the files of the
COMMITTEE FOR THE
STUDY OF MATERNAL MORTALITY

Annual Report of the Kentucky Maternal Mortality Committee*

THIS is a report of maternal deaths that occurred in Kentucky for the years 1960-61-62. The following tables contain information obtained by the State Office of Biostatistics and by the Maternal Mortality Committee. Two sets of tables are included. The numbered tables (1, 2, 3, etc.) contain the statistical analyses of deaths recorded by the Office of Biostatistics. These figures are obtained in accordance with the International Classification of deaths and are therefore the figures on maternal mortality which are comparable with the statistics from other states and/or countries, because of the standardized procedure of classification used.

The numbered and lettered tables (1a, 2a, 3a, etc.) contain the statistical analyses of the deaths reported by the office of Biostatistics plus the study of additional deaths found by the Maternal Mortality Committee. This is so because in an effort to determine more correctly the actual number of deaths occurring in Kentucky, the Maternal Mortality Committee through the Maternal and Child Health Division of the State Department of Health began in 1960 to review all death certificates of females between 15-44 years of age. Many unrecorded maternal deaths were found in this way. These figures give us more realistic information of maternal deaths in the State of Kentucky, but cannot be used for comparative purposes. Nevertheless, to emphasize the importance of this new method of review of death certificates, these numbered and lettered tables with the corrected (unofficial) figures follow:

** Additional tables concerning maternal mortality in Kentucky will be published on the next regularly scheduled Maternal Mortality Page in the February issue of The Journal.*

TABLE 1—Maternal Deaths by Occurrence and Age from Biotatistics

	1962		1961		1960	
Age Group	Deaths	Rate	Deaths	Rate	Deaths	Rate
Total — all ages	29	4.1	40	5.6	29	4.0
15 - 19	2	1.6	5	3.7	—	—
20 - 24	3	1.2	10	4.1	2	0.8
25 - 29	7	4.5	8	5.0	9	5.5
30 - 34	7	7.1	8	7.9	7	6.7
35 - 39	10	18.1	6	10.2	7	11.4
40 and over	—	—	3	15.6	4	19.9

TABLE 1a—Maternal Deaths by Occurrence and Age Group; from Committee Study

	1962		1961		1960	
Age Group	Deaths	Rate	Deaths	Rate	Deaths	Rate
Total — all ages	42	5.9	50	6.8	41	5.6
15 - 19	3	2.3	7	5.2	3	2.3
20 - 24	4	1.7	12	5.0	3	1.3
25 - 29	12	7.7	11	6.9	13	8.0
30 - 34	8	8.2	9	8.9	10	9.5
35 - 39	15	27.2	7	11.9	7	11.4
40 and over	—	—	4	20.8	5	24.8

TABLE 2—Maternal Deaths by Occurrence, by Attendant, from Biostatistics

	Total		Physician		Midwife		Other		Not Stated
Year	Deaths	Rate	Deaths	Rate	Deaths	Rate	Deaths	Rate	Deaths
1962	29	4.1	25	3.6	1	4.7	3	198.7	—
1961	40	5.5	33	4.7	3	13.4	4	272.1	—
1960	29	3.9	24	3.4	2	8.6	3	173.4	—

TABLE 2a—Maternal Deaths by Occurrence by Attendant, from Committee Studies

	Total		Physician		Midwife		Other		Not Stated
Year	Deaths	Rate	Deaths	Rate	Deaths	Rate	Deaths	Rate	Deaths
1962	42	5.9	38	5.5	1	4.7	3	198.7	—
1961	50	6.8	43	6.1	3	13.4	4	272.1	—
1960	41	5.6	35	4.9	2	8.6	3	173.4	1

In Memoriam

JAMES W. T. FULLER, M.D.
Mayfield, Ky.
1902 - 1964

James W. T. Fuller, M.D., 62, Mayfield surgeon, died October 29 enroute to a St. Louis Hospital for treatment of an accidentally inflicted gunshot wound. Doctor Fuller started practice in Mayfield in 1928 following his graduation in 1926 from the Eclectic Medical College of Cincinnati. The son of a Graves County physician, he saw active service in the U.S. Navy Medical Corps from 1942-46, and retired from the Navy in 1954 with the rank of rear admiral.

VIRGIL LEE POWELL, M.D.
Paducah, Ky.
1884 - 1964

Virgil Lee Powell, M.D., 80, Paducah general surgeon, died November 4 following a long illness. Doctor Powell, who had been in practice at Paducah since his graduation in 1910 from the Medical Department of the University of Louisville, had for more than 50 years been a surgeon for the Illinois Central Railroad. He was a member of a number of medical organizations, in which he took an active part.

WILLIAM PERRY HUMPHREY, M.D.
Sturgis, Ky.
1913 - 1964

William P. Humphrey, M.D., 51, died October 10 at Sturgis following a long illness. A 1942 graduate of the Louisiana State University School of Medicine, he had been in general practice at Sturgis from 1944 until his retirement due to ill health. Doctor Humphrey had been a member of the city council for many years in addition to other civic and medical activities. He was the son of the late Ben. F. Humphrey, M.D.

WILLIAM PROCTOR CAWOOD, M.D.
Harlan, Ky.
1883 - 1964

William P. Cawood, M.D., 81, retired Harlan County surgeon, died October 15 following a long illness. Doctor Cawood, who graduated in 1907 from the Medical Department of the University of Louisville, began practice at Evarts, then went to Harlan, where he had remained since. He was known widely for his interest and activity in politics and civic affairs. Doctor Cawood was a past president of the Harlan County Medical Society.

GILBERT ADAMS COOK, M.D.
North Middletown, Ky.
1879 - 1964

Gilbert A. Cook, M.D., 84, retired North Middletown general practitioner, died October 10 at Paris. Doctor Cook had practiced at North Middletown since his graduation from the Medical Department of the University of Louisville in 1905. He was an active church member and a 50 year Mason.

GEORGE PURDY, M.D.
New Liberty, Ky.
1879 - 1964

George Purdy, M.D., 85, Owen County general practitioner for 55 years, died October 16 at Peewee Valley following a long illness. Doctor Purdy, a 1904 graduate of the Medical Department at the University of Louisville, practiced at New Liberty from that time until his retirement in 1959. He had been active in local civic and church affairs and was a former president of the Citizens Bank of New Liberty.

ROBERT D. HIGGINS, M.D.
(Formerly) Ashland, Ky.
1894 - 1964

Robert D. Higgins, M.D., former Ashland Public Health Officer, died October 8 in New York City where he was attending a medical meeting. Doctor Higgins, who had practiced medicine in Ashland after his graduation from the University of Louisville School of Medicine in 1917 until 1941, had recently been practicing in association with the North Carolina Department of Health at Raleigh.

THOMAS A. PEASE, M.D.
(Formerly) Cunningham, Ky.
1887 - 1964

Thomas A. Pease, M.D., 77, retired general practitioner, died November 1 at his home in Chula Vista, Calif., where he had lived since 1959. Doctor Pease, who graduated in 1912 from the Eclectic Medical College of Cincinnati, practiced in Cincinnati until 1935, when he returned to his home at Cunningham to practice until 1959.

* * *

AMA Lecture Given at Morehead

I. Frank Tullis, M.D., professor of medicine and chairman of the department of medicine at the University of Tennessee, addressed Morehead State College students and faculty Monday, November 23, as a part of the AMA lecture series. Doctor Tullis spoke on "Body Changes During Weight Reduction of Obese Individuals".

U.C. Schedules Pediatric Course

"Pediatric Aspects of Surgery in Childhood" will be the topic of the second annual Postgraduate Course in Pediatrics to be held by the department of Pediatrics of the University of Cincinnati College of Medicine May 24 and 25, 1965. Registration will be limited to 50. A fee of $50 will be charged. Address all inquiries to William Schubert, M.D., The Children's Hospital, Cincinnati, Ohio, 45229.

Councils and Committees of the Councils, Standing and Miscellaneous Committees for the 1964-65 Associational Year

Council on Scientific Assembly

Delmas M. Clardy, M.D., Hopkinsville, Chairman
Everett H. Baker, M.D., Louisville, Vice-Chairman
Harvey Chenault, M.D., Lexington
Douglas M. Haynes, M.D., Louisville
Benjamin B. Jackson, M.D., Louisville
Clyde T. Moore, M.D., Fern Creek
Edmund D. Pellegrino, M.D., Lexington

Scientific Program Committee

Douglas M. Haynes, M.D., Louisville, Chairman
Harvey Chenault, M.D., Lexington
Delmas M. Clardy, M.D., Hopkinsville
Eugene H. Conner, M.D., Louisville
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If you have patients who are planning foreign travel, you are urged to remind them that the most important document for foreign travel (next to the passport) is the "International Certificates of Vaccination".

World travelers who forget this fact run into delays in quarantine because they fail to present a valid international certificate of vaccination against smallpox.

In the U. S. the certificate is published as Public Health Service Form 731, "International Certificates of Vaccination", revised June 1961. It is given out with the passport application and also may be obtained from the local and State health departments or from offices of the USPHS. To be valid for international travel the certificate must be completed in every detail.

Lesions of the Pancreas

Continued from Page 943

marred, because some patients continue to drink and succumb from the effects of their chronic alcoholism, diabetes and malnutrition. However, in the patients who have ceased to drink, the results of the procedure have been excellent. When obstructive jaundice, from a stricture of the bile duct, is present, a bile shunt should be carried out by anastomosing the bile duct above the strictured area to the duodenum or a defunctionalized loop of jejunum.

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1964 CONSTITUTION AND BYLAWS
OF THE
KENTUCKY MEDICAL ASSOCIATION

Revised September 30, 1964

CONSTITUTION

Article I. Name of Association

The name and title of this organization shall be the Kentucky Medical Association.

Article II. Purpose of the Association

The purpose of the Association shall be to federate and bring into compact organization the entire medical profession of the State of Kentucky and to unite with similar associations in other states to form the American Medical Association, with a view to the extension of medical knowledge; the advancement of medical science and charity; the evaluation of the standards of medical education; the enactment and enforcement of just medical laws; the promotion of friendly intercourse among physicians and the guarding and fostering of their material interests; the protection of the members thereof against unjust assaults upon their professional care, skill or integrity; and to the enlightenment and direction of public opinion in regard to the great problems of state medicine so that the profession shall become more capable and honorable within itself and more useful to the public in the prevention and cure of disease and in prolonging and adding comfort to life.

Article III. Component Societies

Component societies shall consist of those medical societies which hold charters from this Association.

Article IV. Composition and Meetings of the Association

The Association shall consist of the members of the component societies but the House of Delegates shall have authority to adopt such bylaws regulating the admission and classification of members as it may deem advisable. The Association shall hold an Annual Meeting and such Special Meetings as may be called pursuant to the bylaws.

Article V. Officers

Section 1. The officers of this Association shall be a President, a President-elect, three Vice-Presidents, a Secretary, a Treasurer, a Speaker and Vice-Speaker of the House of Delegates, a Trustee from each District that may be established, and such other officers as may be provided for in the bylaws.

Section 2. The duties and terms of office of all officers of the Association shall be as prescribed in the bylaws.

Section 3. All officers shall serve until their successors have been elected and installed.

Section 4. All officers shall be elected by the House of Delegates at its Regular Session and shall take office on the last day of the Annual Meeting.

Article VI. House of Delegates

Section 1. The House of Delegates shall be the legislative body of the Association and shall have power, by a two-thirds vote of all the delegates present at that session, to adopt bylaws to carry out the provisions of this Constitution and to provide for the government of the Association in any other manner not inconsistent with this Constitution. It shall meet in Regular Session annually during the Annual Meeting of the Association, and may be called into Special Session under such conditions as may be prescribed in the bylaws.

Section 2. Delegates shall be members of and elected by component societies in such manner as may be provided in the bylaws. Officers of the Association, Delegates and Alternate Delegates to the American Medical Association, and the five immediate Past Presidents shall be ex officio members of the House of Delegates and entitled to vote.

Section 3. The House of Delegates shall elect a Speaker and a Vice-Speaker, one of whom shall preside during the meetings of the House of Delegates. The presiding officer shall not be entitled to a vote except in the event of a tie.

Section 4. The House of Delegates shall be the final judge as to the qualification of its members.

Article VII. Districts, Sections and District Societies

The House of Delegates shall divide the state into Districts composed of one or more counties, for administrative purposes. It may also provide for a division of the scientific work of the Association into appropriate Sections, and for the organization of such District Societies, composed exclusively of members of component societies, as will promote the best interests of the profession.

Article VIII. Board of Trustees

The House of Delegates shall make provision in the bylaws for a Board of Trustees composed of one Trustee from each District and such of the other officers of the Association as the House may deem appropriate, which shall be charged with the general direction of the Association's affairs during the interim between meetings of the House. The House may delegate such powers to the Board of Trustees as are not specifically required by this Constitution to be exercised by the House, and may limit the Board's powers to such extent as it may determine to be necessary or desirable. Provided, however, that in no event shall the Board of Trustees have power to commit the Association to any course of action which is contrary to or at variance with any policy established by the House of Delegates.

Article IX. Funds and Expenses

The House of Delegates shall provide funds for meeting the expenses of the Association by such methods and from such sources as it may select,

including but not limited to an equal per capita assessment by class of membership, upon each component county society. Funds may be appropriated by the House of Delegates to defray the expenses of the annual session, for publications and for such other purposes as will promote the welfare of the Association and the profession.

Article X. Referendum

The membership of the Association, by written petition signed by not less than 10% of the active membership, may obtain a referendum on any question pending before the House of Delegates. The Secretary, upon the presentation of such a petition to him shall cause the question to be submitted to the active membership by mail, and if a majority of the active members shall signify its approval or disapproval of a certain policy or course of action with respect to the question thus submitted, the will of the majority shall determine the question and shall be binding upon the House of Delegates and the Association upon certification of the result of the vote by the Secretary to the President and Board of Trustees.

Article XI. The Seal

The Association shall have a common Seal with power to break, change or renew the same at pleasure.

Article XII. Amendments

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates registered at the Regular Session, provided that such amendment shall have been presented in open meeting at the previous regular session, and that it shall have been sent officially to each component county society at least two months before the session at which final action is to be taken.

Article XIII. Definitions

Whenever used in this Constitution, the Articles of Incorporation or the Bylaws—

(a) "County society," "component county society," or "component medical society" means "component society."

(b) "Annual Meeting" means the annual three-day meeting of the Association.

(c) "Scientific Sessions" mean those sessions during the Annual Meeting at which scientific subjects are programmed and discussed.

(d) "Regular Session" means the regular session of the House of Delegates which is held during the Annual Meeting.

(e) "Special Session" means a special, called meeting or session of the House of Delegates.

BYLAWS

CHAPTER 1. MEMBERSHIP

Section 1. Membership in this Association shall be coterminous with membership in a component county society. No physician shall be eligible for membership in this Association unless he is a member, in good standing of a component society, nor may he maintain membership in a component county society unless he is a member, in good standing of this Association.

When a physician who meets the qualifications hereinafter set forth, is certified to the Secretary as a member in good standing of a component society, properly classified as to type of membership, and when the dues pertaining to his membership classification have been received by the Secretary of the Association, the name of the member shall be included in the official roster of the Association and he shall be entitled to all the privileges of his class of membership. Provided, however, that members in good standing from other state societies may, if admitted to membership by a component society, be accepted by KMA for membership without paying dues for the remainder of the calendar year in which the transfer is made. Provided further, that the Board of Trustees shall have power, upon written application, approved annually by the county society of which the applicant is a member, to excuse any member from the payment of dues because of financial hardship.

Section 2. Membership in the Association shall be divided into seven classes, to-wit: Active, Emeritus, Associate, Inactive, Student, Honorary and Special.

(a) Active Members. The active membership of the Association shall consist of the active members of the various component county medical societies. To be eligible for active membership in any component county society, the applicant must be a doctor of medicine of good moral, ethical, and professional standing, who is licensed to practice medicine in Kentucky.

(b) Emeritus Members. Component societies may elect as a member-emeritus any doctor of medicine who is 70 years of age or who has retired from active practice and who has previously maintained active membership in good standing in his own society for twenty years or more. Emeritus members shall have the right to vote but shall not pay dues, hold office or be entitled to the benefits of Chapter VI, Section 9 of these Bylaws. They shall receive the Journal and other publications of the Association.

(c) Associate Members. The associate membership of the Association shall consist of the associate members of the various component county medical societies. To be eligible for associate membership in any component county society, the applicant must be ineligible for active membership and qualify under one or more of the following groups:

(1) Medical officers of the United States Army, Navy, Air Force, Veterans Administration, Public Health Service, or other governmental service while on duty in the State.

(2) Interns, residents or teaching fellows who are doctors of medicine and who have complied with all pertinent regulations of the State Board of Health.

Associate members shall not have the right to vote nor to hold office, but shall receive the Journal and other publications of the Association.

(d) Inactive Members. The inactive membership of the Association shall consist of the inactive members of the various component county societies. Any doctor of medicine licensed to practice medicine in Kentucky who is not engaged in the practice of medicine but who is otherwise eligible for active membership in the Association may be admitted to inactive membership by any component county society. Inactive members shall not have the right to vote nor hold office, but shall receive the Journal and other publications of the Association.

(e) Student Members. Any student in an accredited medical school in Kentucky or any resident of Kentucky who is a student in any accredited medical school in the United States shall be eligible for student membership. Student members shall not have the right to vote nor hold office. They may apply directly to the State Association for membership and be assigned to the county society of

their choice. Student members shall receive the Journal of the Association. The membership year for student members shall run from September 1 to August 31 of each year.

(f) Honorary Members. Any physician possessed of scientific attainments who is a member of a constituent state medical association and who has participated in the program of the scientific session and who is not a citizen of Kentucky may by unanimous vote of the House of Delegates be elected to honorary membership. Honorary members shall be entitled to the privileges of the floor in all scientific sessions.

(g) Special Members. Component societies may invite dentists, pharmacists, funeral directors, or other professional persons to become special members. Special members shall have no rights or obligations under these Bylaws, but may be accorded the privilege of attending and participating in the scientific meetings of the society. Provided, however, that a registration fee may be required of special members who desire to attend the Annual Meeting of the Association.

Section 3. Guests of Honor. Any distinguished physician not a resident of this State may become a guest of honor during any Annual Meeting upon invitation of the Board of Trustees and shall be accorded the privilege of participating in all of the scientific work of that meeting.

Section 4. Except as provided in Chapter VI, Section 4 of these Bylaws, no person who is under sentence of suspension or expulsion from any component society of this Association, shall be entitled to any of the rights or benefits of membership in this Association.

Section 5. Every active member shall occupy a provisional status for two years immediately following his admission to membership in the Association, during which period he must successfully complete an orientation course to be presented at stated intervals by the Board of Trustees or one of its committees. The form and content of this course shall be prescribed by the Board and unless excused by the Board for good cause shown, failure to attend and successfully complete the course within the two-year period shall automatically revoke the delinquent's membership and terminate all of his rights and privileges as a member, and he shall thereafter, for a period of one year, be ineligible for membership in any component county society.

CHAPTER II. ANNUAL AND SPECIAL MEETINGS OF THE ASSOCIATION

Section 1. The Association shall hold its annual and special meetings at such times and places as may be determined by the House of Delegates.

Section 2. The Annual Meeting shall consist of one or more scientific sessions, at least two meetings of the House of Delegates, and such other gatherings as may be authorized by the Board of Trustees. Each scientific session shall be presided over by the President or in his absence or disability or at his request by the President-Elect or one of the vice presidents. The entire time of the scientific sessions, as far as may be, shall be devoted to papers and discussions related to scientific medicine.

Section 3. The name of a physician upon the properly certified roster of members or list of delegates of a component society which has paid its annual assessment, shall be prima facie evidence of his right to register at any meeting of this Association.

Section 4. Each member in attendance at any meeting shall enter his name on the registration book indicating the component society of which he is a member. When his right to membership has been verified by reference to the roster of the society, he shall receive a badge which shall be evidence of his right to all the privileges of membership at that meeting. No member or delegate shall take part in any of the proceedings of any meeting until he has complied with the provisions of this section.

CHAPTER III. THE HOUSE OF DELEGATES

Section 1. The House of Delegates shall meet in Regular Session at the time and place of the Annual Meeting, and shall, insofar as is practicable, fix its hours of meeting so as to give delegates an opportunity to attend the scientific sessions and other proceedings. Provided, however, that if the business interests of the Association and profession require, the Speaker, with the consent of the Board of Trustees, may convene the Regular Session in advance of the Annual Meeting, and the House may remain in session after the final adjournment thereof.

Section 2. The House may be called into Special Session by the President with the approval of the Board of Trustees, and a special session shall be called by the President on the written request of delegates representing fifty or more component societies. The purpose of all special sessions shall be stated in the call, and all business transacted at any such special session shall be germane to the stated purpose.

Section 3. When a special session is called, the Secretary shall mail a notice of the time, place, and purpose of such meeting to the last known address of each delegate at least ten days before such session.

Section 4. The Speaker shall, by virtue of his office, be responsible for making all arrangements for all sessions, regular or special, of the House.

Section 5. In the event a component society is not represented at any meeting of the House, the Speaker shall consult with any officer of the component society who is in attendance and, with the approval of the Credentials Committee, may appoint any active members of such component society who is in attendance, as its alternate delegate. If no officer of such society is present, the Speaker may make the appointment without consultation, but with the approval of the Credentials Committee. All such appointments shall also be subject to the approval of the House.

Section 6. Forty per cent of the qualified delegates, as defined by Article VI of the Constitution, shall constitute a quorum and all of the meetings of the House shall be open to the members of the Association. The House shall have the right to go into executive session whenever in its judgment such action is indicated; except that active members of the Association shall have the right to attend all executive sessions.

Section 7. Each resolution introduced into the House shall be in writing and signed by the author and presented to the Secretary following its introduction. If the author be an individual member, it shall be signed by him. If the author be a group of members, it shall be signed by the authorized spokesman for that group. Immediately after the Delegate has introduced the Resolution, it shall be referred to the proper Reference Committee before action thereon is taken.

Section 8. No new business shall be introduced in the last meeting of the House without unanimous consent, except when presented by the Board of Trustees. All new business so presented shall require the affirmative vote of three-fourths of those delegates present and voting, for adoption.

Section 9. The House shall give diligent attention to and foster the scientific work and spirit of the Association, and shall constantly study and strive to make each Annual Meeting a stepping stone to further ones of higher interest.

Section 10. It shall consider and advise as to the material interests of the profession, and of the public in those important matters wherein the public is dependent upon the profession, and shall use its influence to secure and enforce all proper medical

and public health legislation, and to diffuse information in relation thereto.

Section 11. It shall make careful inquiry into the condition of the profession of each county in the State, and shall have authority to adopt such methods as may be deemed most efficient for building up and increasing the interest in such county societies as already exist and for organizing the profession in counties where societies do not exist. It shall especially and systematically endeavor to promote friendly intercourse between physicians of the same locality and shall continue these efforts until every physician in every county of the State who will agree to abide by the constitution, bylaws and other rules and regulations of the Association and the appropriate component society, has been brought under medical society influence.

Section 12. It shall encourage postgraduate work in medical centers as well as home study and research and shall endeavor to have the results of the same utilized and intelligently discussed in the county societies.

Section 13. It shall elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and Bylaws of that body.

Section 14. It shall, upon application, provide and issue charters to county societies organized in conformity with the Constitution and Bylaws of this Association.

Section 15. The state shall be divided into the following districts:

No. 1.—Ballard, Calloway, Carlisle, Fulton, Graves, Hickman, Livingston, McCracken, and Marshall.

No. 2—Daviess, Hancock, Henderson, McLean, Ohio, Union, and Webster.

No. 3—Caldwell, Christian, Crittenden, Hopkins, Lyon, Muhlenberg, Todd, and Trigg.

No. 4—Breckinridge, Bullitt, Grayson, Green, Hardin, Hart, Larue, Marion, Meade, Nelson, Taylor, and Washington.

No. 5—Jefferson.

No. 6—Adair, Allen, Barren, Butler, Cumberland, Edmonson, Logan, Metcalf, Monroe, Simpson, and Warren.

No. 7—Anderson, Carroll, Franklin, Gallatin, Grant, Henry, Oldham, Owen, Shelby, Spencer, and Trimble.

No. 8—Boone, Campbell, and Kenton.

No. 9—Bath, Bourbon, Bracken, Fleming, Harrison, Mason, Nicholas, Pendleton, Scott, and Robertson.

No. 10—Fayette, Jessamine, and Woodford.

No. 11—Clark, Estill, Jackson, Lee, Madison, Menifee, Montgomery, Owsley, Powell, and Wolfe.

No. 12—Boyle, Casey, Clinton, Garrard, Lincoln, McCreary, Mercer, Pulaski, Rockcastle, Russell, and Wayne.

No. 13—Boyd, Carter, Elliott, Greenup, Lawrence, Lewis, Morgan, and Rowan.

No. 14—Breathitt, Floyd, Johnson, Knott, Letcher, Magoffin, Martin, Perry, and Pike.

No. 15—Bell, Clay, Harlan, Knox, Laurel, Leslie, and Whitley.

District meetings may be held as desired, and District Medical Associations may be organized as desired, according to the districts outlined above.

Section 16. It shall have authority to appoint committees for special purposes from among members of the Association who are not members of the House of Delegates and such committees may report to the House of Delegates in person, and may participate in the debate thereon.

Section 17. Except as provided in Chapter VI, Section 4, it shall approve all memorials and resolutions issued in the name of the Association before the same shall become effective.

Section 18. A digest of proceedings of the House of Delegates shall be published in the Journal of the Association.

CHAPTER IV. ELECTION OF OFFICERS

Section 1. The President-Elect and the Vice Presidents shall be elected for a term of one year. The Speaker of the House of Delegates, the Vice-Speaker of the House, the Secretary and the Treasurer shall be elected for terms of three years. The Trustees shall be elected for terms of three years and shall be limited to serving for not more than two consecutive full terms. The terms of the Trustees shall be so arranged that one-third of the terms expire each year, insofar as possible. No member shall be eligible for the office of President, President-Elect, Vice President, Speaker or Vice Speaker of the House of Delegates, or Trustees, who has not been an active member of the Association for at least five years.

Section 2. During the last meeting of the regular session of the House of Delegates, the Speaker of the House of Delegates shall submit to the members of the House of Delegates a list of ten names from which, by ballot, the House of Delegates shall select five members to serve as the nominating committee for the next year. The five names receiving the most votes shall form the committee. The Committee shall select one of its members as chairman at an organization meeting held during the Interim Meeting, or at some other appropriate place designated by the Board of Trustees at least four months before the Annual Meeting. The Committee, in addition to such other meetings as it may choose to hold, shall schedule an open meeting immediately after the close of the first meeting of the House at each Annual Meeting. This open meeting shall be held in the meeting place of the House of Delegates, shall receive broad publicity, and those who have business to discuss with the Committee shall have a hearing. Before noon of the following day, the Committee shall post a bulletin board near the entrance to the hall in which the Annual Meeting is being held, its nominations for each office to be filled, and shall formally present said nominations to the House at the time of the election. Additional nominations may be made from the floor by submitting the nominations without discussions or comment.

Section 3. The election of officers shall be held at the second meeting of the regular session of the House of Delegates.

Section 4. All elections shall be by secret ballot, and a majority of the votes cast shall be necessary to elect. Provided, however, that when there are more than two nominees, the nominee receiving the least number of votes on the first ballot shall be dropped and the balloting shall continue in like manner until an election occurs.

Section 5. Any member known to have directly or indirectly solicited votes for, or sought any office within the gift of the Association shall be ineligible for any office for two years.

Section 6. The Delegates representing the counties in each District shall form the Nominating Committee for the purpose of nominating a Trustee for the District concerned. This committee shall hold a well publicized meeting open to all active members of the District concerned who are in attendance at the Annual Meeting, for the purpose of discussing the nomination for the Trustee to serve the District. Additional nominations may be made from the floor when the Nominating Committee makes its report to the House of Delegates.

CHAPTER V. DUTIES OF OFFICERS

Section 1. Except as provided in Chapter II, Section 2 hereof, the President shall preside at all scientific sessions of the Association and shall appoint all committees not otherwise provided for. He shall deliver an annual address at such time as may be arranged and shall perform such duties as custom and parliamentary usage may require. He shall be the real head of the profession in the State during his term of office

and so far as practicable, shall visit by appointment, the various sections of the State and assist the Trustees in building up the county societies and in making their work more practical and useful. He shall be reimbursed for his reasonable and necessary travel expense incurred in the performance of his duties as President, in an amount not to exceed the total amount appropriated for that purpose in the annual budget.

Section 2. The President-Elect shall assist the President in visitation of county and other meetings. He shall become president of the Association at the next Annual Meeting following his election as president-elect. In the event of his death or resignation, or if he becomes permanently disqualified or disabled, his successor shall be elected by the House of Delegates and shall be installed as President of the Association at its next regular session.

Section 3. The Vice Presidents shall assist the President in the discharge of his duties, and shall perform such other duties as may be prescribed by the Board of Trustees. In the event of a vacancy in the office of the President, the Vice President from the district from which the President was elected shall succeed to the office of the President.

Section 4. The President-Elect and the Vice Presidents, when acting for and in behalf of the President, may be reimbursed for their reasonable and necessary travel expenses incurred in the performance of their duties, in such amounts as may be available out of the sum appropriated in the annual budget for traveling expenses of the President.

Section 5. The Speaker of the House shall preside at all meetings of the House of Delegates. He shall appoint all committees of the House of Delegates with the approval of the House of Delegates. He shall be a non-voting member of said committees, and shall perform such other duties as custom and parliamentary usage may require.

Section 6. The Vice Speaker shall assume the duties of the Speaker in his absence, and shall assist the Speaker in the performance of his duties. In the event of the death, disability, resignation, or removal of the Speaker, the Vice Speaker shall automatically become Speaker of the House of Delegates.

Section 7. The Secretary shall advise the Executive Secretary in all secretarial matters of this Association and shall act as the corporate secretary insofar as the execution of official documents or institution of official actions are required. He shall perform such duties as are placed upon him by the Constitution and Bylaws, and in the event of the death, resignation or removal of the Executive Secretary, shall assume the duties of that office until the vacancy is filled.

Section 8. The Treasurer shall demand and receive all funds due the Association, including bequests and donations. He shall, if so directed by the House of Delegates, sell or lease any real estate belonging to the Association and execute the necessary papers and shall, subject to such direction, have the care and management of the fiscal affairs of the Association. All vouchers of the Association shall be signed by the Secretary or the Executive Secretary and shall be countersigned by the Treasurer of the Association. Under unusual circumstances, when one or more of the above-named officials are not readily available, the President or the Chairman of the Board of Trustees is authorized to sign the vouchers, provided that in any event all vouchers of the Association shall bear a signature and a counter-signature. All five officials shall be required to give bond in an amount to be determined by the Board of Trustees. The Treasurer shall report the operations of his office annually to the House of Delegates, via the Board of Trustees, and shall truly and accurately account for all funds belonging to the Association and coming into his hands during the year. His accounts shall be audited annually by a certified public accountant appointed by the Board of Trustees.

CHAPTER VI. BOARD OF TRUSTEES

Section 1. The Board of Trustees shall be the executive body of the House of Delegates and between sessions of the House of Delegates shall exercise the powers conferred upon the House of Delegates by the Constitution and Bylaws. The Board of Trustees shall consist of the duly elected Trustees and the President, the President-Elect, the three Vice Presidents, the immediate Past-President, the Speaker, and Vice-Speaker of the House of Delegates, the Secretary, the Treasurer, and the Delegates to the American Medical Association. The Executive Committee of the Board of Trustees shall consist of the President, the President-Elect, the Secretary, the Chairman of the Board of Trustees, the Vice Chairman of the Board of Trustees, and two Trustees to be elected annually by the Board of Trustees. A majority of the full Board, to-wit, 14, and a majority of the full Executive Committee, to-wit, 4, shall constitute a quorum for the transaction of all business by either body. Between sessions of the Board, the Executive Committee shall exercise all of the powers belonging to the Board except those powers specifically reserved by the Board to itself.

Section 2. The Board shall meet daily, or as required, during the Annual Meeting of the Association and at such other times as necessity may require, subject to the call of the Chairman or on petition of three Trustees. It shall meet on the last day of the Annual Meeting for reorganization and for the outlining of the work for the ensuing year. It shall, through its Chairman, make an annual report to the House of Delegates at such time as may be provided, which report shall include an audit of the accounts of the Treasurer and other agents of this Association and which shall also specify the character and cost of all the publications of the Association during the year, and the amounts of all other property belonging to the Association, or under its control, with such suggestions as it may deem necessary. By accepting or rejecting this report, the House may approve or disapprove the action of the Board of Trustees in whole or in part, with respect to any matter reported upon therein. In the event of a vacancy in any office other than that of President, the Board may fill the same until the annual election.

Section 3. Each Trustee shall be organizer, peacemaker and censor for his district. He shall visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession and for improving and increasing the zeal of the existing component societies and their members. He shall likewise hold at least one district meeting each year in order to afford a forum for the exchange of views on problems relating to organized medicine and for postgraduate scientific study. The necessary traveling expenses incurred by a Trustee in the line of his duties herein imposed may be paid by the Treasurer upon a proper itemized statement, but this shall not be construed to include his expenses in attending the Annual Meeting of the Association.

Section 4. The Board shall have the right to communicate the views of the profession and of the Association in regard to health, sanitation, and other important matters, to the public and press. Such communications shall be signed by the President of the Association and the Chairman of the Board.

Section 5. The Journal of the Kentucky Medical Association shall be the official organ of the Association and shall be published under the supervision of the Board. The Editor of the Journal shall be elected by the Board. All money received by the Journal or by any member of its staff on its behalf, shall be paid to the Treasurer on the first of each month. The Board shall provide for and superintend the publication and distribution of all proceedings, transactions, and memoirs of the Association, and shall have authority to appoint such assistants to the Editor as it deems necessary.

Section 6. All commercial exhibits during the Annual Meeting shall be within the control and direction of the Board.

Section 7. In the event of the death, resignation, removal or disability of a Trustee, between sessions of the House of Delegates, the President may call a meeting of the delegates of record from the counties of that district for the purpose of submitting one or more nominees as candidates to fill the office until the Trustee's disability is removed or until the next meeting of the House of Delegates. The name or names of the nominee or nominees shall be submitted to the Board, which may elect an acting Trustee from them.

Section 8. The Association, upon the request of any member in good standing who is a defendant in a professional liability suit, will provide such member with the consultative service of competent legal counsel selected by the Secretary acting under the general direction of the Executive Committee. In addition, the Association may, upon application to the Board outlining unusual circumstances justifying such action, provide such member with the services of an attorney selected by the Board to defend such suit through one court.

Section 9. The Board shall employ an Executive Secretary whose principal duty shall be to carry out and execute the policies established by the House of Delegates and the Board. His compensation shall be fixed by the Board. The Executive Secretary shall act as general administrative officer and business manager of the Association and shall perform all administrative duties necessary and proper to the general management of the Headquarters Office, except those duties which are specifically imposed by the Constitution and Bylaws upon the officers, committees, councils and other representatives of the Association. He shall refer to the various elected officials all administrative questions which are properly within their jurisdiction.

He shall attend the Annual Meeting, the meetings of the House of Delegates, the meetings of the Board, as many of the committee and council meetings as possible, and shall keep separately the records of their respective proceedings. He shall, at all times, hold himself in readiness to advise and aid, so far as is possible and practicable, all officers, committees, and councils of the Association in the performance of their duties and in the furtherance of the purposes of the Association. He shall be allowed traveling expenses to the extent approved by the Board.

He shall be the custodian of the general papers and records of the Association (including those of the Treasurer) and shall conduct the official correspondence of the Association. He shall notify all members of meetings, officers of their election, and committees and councils of their appointment and duties.

He shall account for and promptly turn over to the Treasurer all funds of the Association which come into his hands. It shall be his duty to receive all bills against the Association, to investigate their fairness and correctness, to prepare vouchers covering the same, and to forward them to the Treasurer for appropriate action. He shall keep an account with the component societies of the amounts of their assessments, collect the same, and promptly turn over the proceeds to the Treasurer. He shall within thirty days preceding each Annual Meeting, submit his financial books and records to a certified public accountant, approved by the Board, whose report shall be submitted to the House of Delegates.

He shall keep a card index register of all practitioners in the State by counties, noting on each his status in relation to his county society and upon request shall transmit a copy of this list to the American Medical Association.

He shall act as Managing Editor of the Journal of the Kentucky Medical Association under supervision of the Board and in a similar capacity to the extent that other publications are authorized by the House of Delegates.

He shall perform such additional duties as may be required by the House of Delegates, the Board, or the President, and shall employ such assistants as the Board may direct. He shall serve at the pleasure of the Board, and in the event of his death, resignation, or removal, the Board shall have the power to fill the vacancy. From time to time, or as directed by the Board, he shall make written reports to the Board and House of Delegates concerning his activities and those of the Headquarters Office.

CHAPTER VII. DISCIPLINE — THE JUDICIAL COUNCIL

Section 1. There is hereby created a Judicial Council composed of the Secretary of the Association and four members to be elected by the House of Delegates for terms of four years each. One member shall be elected from each of the traditional eastern, western, and central districts, and one member from the state at large. Members of the first Judicial Council shall be elected for terms of one, two, three, and four years, respectively so that thereafter, one member will be elected each year. The Council shall annually elect a chairman.

To be eligible for membership on the Judicial Council, a nominee shall possess at least one of the following qualifications: (1) Have served one term as an officer, trustee, or as Delegate to the AMA or (2) Have served five years as a member of the House of Delegates.

It shall be the duty of the Board of Trustees to nominate at least one candidate for each vacancy on the Judicial Council, but additional nominations may be made from the floor. Vacancies which occur between Regular Sessions of the House of Delegates, shall be filled by the Board of Trustees. No member, other than the Secretary, shall serve more than two consecutive terms.

Section 2. The Judicial Council shall be the Board of Censors of the Association. It shall be the final arbiter of all questions involving the right and standing of members, whether in relation to other members, to the component societies, or to this Association. All questions of an ethical nature brought before the House of Delegates shall be referred to the Judicial Council without discussion. A member who has been convicted of a felony or of any violation of the Medical Practice Act, or who violates any of the provisions of the constitution, bylaws, or any rule or regulation of this Association, or the Principles of Ethics of the American Medical Association shall be liable to censure, fine, suspension, or expulsion upon order of the Judicial Council. Provided, however, that if in addition to discipline by the Association, the Judicial Council shall be of the opinion that the offending member's license to practice medicine should be revoked, it shall report this to the Board of Trustees as a recommendation that the Board refer the matter to the State Board of Health for this purpose.

At the request of any member or aggrieved individual involved, the Judicial Council may initiate disciplinary proceedings against any member, and may intervene in or supersede county, individual trustee, or district disciplinary proceedings whenever in its sole judgment and opinion, a disciplinary matter is not being handled in an expeditious manner, and may render a decision therein. In all such cases of initiation, intervention, or supersession, the due process requirements of reasonable notice and a full and fair hearing shall be observed. No recommended disciplinary decision of an individual trustee or any district grievance committee shall become effective unless and until approved by the Judicial Council.

Section 3. It shall consider all appeals from the recommended decisions of individual trustees and District Grievance Committees. In the case of ap-

peals from the decisions of individual trustees, the Judicial Council may admit such oral or written evidence as in its judgment will best and most fairly present the facts, but all appeals from the recommended decisions of District Grievance Committees shall be considered on the record made before such committee. It shall be the duty of the Secretary to notify the parties with respect to its disposition of each case.

Section 4. The Judicial Council may hear appeals from the disciplinary orders of component societies. Provided, however, that such appeals shall be considered on the record made before the component societies.

Section 5. Efforts toward conciliation and compromise shall precede the hearing of all disciplinary cases, but the decision of the Judicial Council shall be final.

Section 6. Component societies are encouraged to create suitable disciplinary procedures which guarantee due process, and to dispose of all disciplinary problems which come to their attention. It is recognized, however, that it may not be feasible for some societies to do so, and the District Grievance Committees hereinafter created, are designed to meet the needs of county societies which are without a functioning grievance committee.

Section 7. The trustee of each district is hereby designated the chairman of his District Grievance Committee. The Judicial Council shall designate two additional trustees from districts adjoining that of the chairman, and the three trustees thus selected shall constitute the District Grievance Committee. All grievances which cannot be resolved by individual trustees, shall be referred to the local grievance committee or the district grievance committee for the district in which the respondent physician or county society resides.

Section 8. District Grievance Committees shall investigate every grievance coming to their attention, taking care that the physician complained of shall have ample opportunity to respond to the complaint. If, after careful investigation, the complaint appears to be without merit, the committee shall so report to the Judicial Council, including sufficient facts in its report to enable the Judicial Council to form its own conclusions.

If the District Grievance Committee's investigation indicates that the member may be a proper subject of disciplinary action, the committee shall, upon reasonable notice, hold a hearing at which the complaint and the respondent shall each be entitled to the counsel of any physician of his choice, to present the testimony of witnesses in his behalf, and to cross-examine witnesses against him. All testimony shall be under oath and shall be recorded by a competent reporter at the expense of the Association, but shall not be transcribed unless and until an appeal is taken as hereinafter provided.

When all of the testimony has been heard and all evidence received, the committee shall make written findings and recomendations which it shall transmit to the Judicial Council, furnishing copies thereof to the parties.

Section 9. Any party aggrieved by the findings or recommendations of the committee, may, within 30 days, appeal to the Judicial Council. Appeals shall be taken by filing with the Secretary a copy of the entire record made before the District Grievance Committee (including a transcript of the testimony, procured at the appellant's expense) together with a written statement of appeal pointing out in detail wherein the committee has erred, and directing the attention of the Judicial Council to those portions of the transcript upon which he relies, provided, however, that the Judicial Council may extend the time in which the transcript must be filed, upon request made within the initial thirty-day period.

CHAPTER VIII. STANDING COMMITTEES AND COUNCILS

Section 1. The Board of Trustees shall, upon nomination of its Executive Committee, appoint and designate the chairmen of four standing committees composed of not less than five nor more than seven members, as follows:

(a) A Committee to Study the Constitution and Bylaws.
(b) A Committee on Third-Party Medicine.
(c) A Committee on Arrangements for the Interim Meeting.
(d) An Advisory Committee to the Editor of the Journal.

Section 2. The Board of Trustees shall, in the same manner, (except as hereinafter provided) appoint and designate the chairmen of six Councils, composed of not less than five nor more than seven members, as follows:

(a) A Council on Scientific Assembly.
(b) A Council on Medical Education and Hospitals.
(c) A Council on Legislative Activities.
(d) A Council on Medical Services.
(e) A Council on Communications and Public Service.
(f) A Council on Allied Professions and Related Groups.

Section 3. The Executive Committee shall serve as the nominating committee for all Standing Committee and Council appointments, but the Trustees may make additional nominations from the floor. When the Executive Committee sits as such nominating committee, the President shall serve as Chairman.

Section 4. Except as otherwise provided herein, members of Standing Committees and Councils shall be appointed for terms of not less than one year and of not more than three years, and until their successors are appointed. Each committee and council (other than the Council on Scientific Assembly) shall meet and organize as soon after its appointment as possible, and shall meet again near the close of the associational year, for the purpose of formulating its annual report. It may meet at such other times as may be necessary or desirable. The Headquarters Office shall be the headquarters for all Committees and Councils, unless otherwise specifically ordered by the Board of Trustees or its Executive Committee.

Five-member Committees and Councils shall have a quorum of three, and seven-member Committees and Councils shall have a quorum of four members present before any business other than the fixing of the time and place of the next meeting, may be transacted.

All committees, other than standing committees, shall be assigned to a council and shall report their activities and recommendations *only* to the council to which assigned. These reports will be reviewed by the various councils and no such reports or recommendations will be considered by the Board of Trustees unless and until reviewed by the proper council.

Each Standing Committee and Council shall report annually, at least six weeks prior to the Annual Meeting, to the House of Delegates via the Board of Trustees respecting its activities during the year last past. These reports shall be transmitted, without alteration or amendment, to the House of Delegates by the Board of Trustees at the Annual Meeting, with such comments or recommendations as the Board cares to make. Committees and Councils may submit supplemental reports if such reports are in the hands of the Secretary at least 48 hours in advance of the first meeting of the Regular Session of the House of Delegates.

Section 5. The President, Secretary, and Executive Secretary shall be ex officio members of all Committees and Councils, without power to vote except as otherwise specified herein.

Section 6. The Board of Trustees shall have power to establish such other committees as may, from time to time, appear to it to be advisable, and to prescribe

their composition, the method of their appointment, and their duties. Such committees shall serve at the pleasure of the Board.

In addition, the Board of Trustees shall have power to appoint a representative from this Association to the Conference of Presidents and such other organizations as it shall determine.

Section 7. The Committee to Study the Constitution and Bylaws shall make a continuing study of the Constitution and Bylaws and shall annually recommend such revisions of either or both of these documents as changing times and conditions indicate.

Section 8. The Committee on Third Party Medicine shall make a continuing study of Third Party Medicine, and shall maintain liaison with all medical care plans which employ physicians on a salaried basis in this state. It shall mediate disputes between members and such plans, and shall continually strive to persuade such plans to shape their relations with their employed physicians and with the public, in conformity to the views of this Association.

Section 9. The Committee on Arrangements for the Interim Meeting shall have the responsibility of preparing the program for the Interim Meeting, and presenting it to the Board of Trustees or its Executive Committee for approval. Upon approval of the program thus presented, the Committee shall have the further responsibility of approving all arrangements for the Conference.

Section 10. The Advisory Committee to the Editor of the Journal shall provide support to the Editor and be available to him for consultation with respect to any matter concerning the Journal, on which he desires the Committee's advice and assistance. All papers of doubtful suitability for publication shall be referred by the Editor to the Advisory Committee, and its approval shall be required prior to the publication of any matter which is recognized to be of a controversial nature.

Section 11. The Council on Scientific Assembly shall consist of seven (7) members. The President, the President-Elect, and the chairmen of the Committees on Scientific and Technical Exhibits shall, by virtue of their respective offices, be voting members of the Council, with the President serving as Chairman and the President-Elect as Vice-Chairman. The remaining three members shall serve for terms of three (3) years each, with the term of one member expiring each year. The Council shall supervise and direct the planning, development and presentation of the scientific programs of the Annual Meeting each year. In addition, it shall be responsible for scientific and technical exhibits and all activities incident to the Annual Meeting, including golf and other forms of recreation and entertainment. These will include the duties heretofore imposed upon the Awards Committee to nominate the recipients of the Distinguished Service Medal, the Outstanding General Practitioner Award, and the R. Haynes Barr Award.

Thirty (30) days previous to each Annual Meeting, the Council shall prepare and issue a program announcing the order in which papers, discussions, and other business shall be presented, which program shall be adhered to as nearly as practicable. No county society, as such, shall serve as host society to the Annual Meeting.

Section 12. The Council on Medical Education and Hospitals shall direct and supervise the activities of the Association in the field of medical education, and shall maintain active liaison with the Kentucky Hospital Association. It shall seek to elevate the standards of postgraduate medical education in Kentucky, establishing and maintaining liaison with Kentucky's two medical schools and the Committee for the American Medical Association Education Research Foundation, and concerning itself with problems relating to medical and hospital care, general practice, and such other matters in this general field as may be referred to it by the Board.

Section 13. The Council on Legislative Activities shall direct and supervise the work of the Association as it pertains to state and national legislation, and shall formulate and submit a legislative program to the Board of Trustees for its consideration. The Council shall seek the enactment of the Association's legislative program into law, and shall resist the enactment of bills which the Board finds to be not in the best interests of the public or the profession. It shall maintain liaison with officials of state and national governments and shall work closely with the various county societies in carrying out the legislative program at both state and national levels.

Section 14. The Council on Medical Services shall supervise and direct the activities of the Association in the field of socio-economic development. It shall be charged with the promotion of voluntary health insurance programs in general and shall maintain active liaison with Kentucky Physicians Mutual, Inc., and Blue Cross plans. It shall advise on medical service contracts with the state and federal governments and shall serve as a clearing house on all fee schedules and other questions affecting the economics of medicine. It shall concern itself with the problem of providing adequate medical care for the aged, and shall maintain careful scrutiny of all state or national programs which purport to deal with this problem.

Section 15. The Council on Communications and Public Service shall supervise and direct all associational activity in the fields of public relations and service, including, but not limited to, rural health, schools, public health, emergency medical services and diabetes.

Section 16. The Council on Allied Professions and Related Groups shall concern itself with the development and promotion of improved health standards and shall establish and maintain liaison with the dental, nursing and pharmacy professions in this state. It shall supervise and direct the Association's activities in the fields of infant and maternal mortality, physical medicine and rehabilitation, industrial medicine, tuberculosis, blood banks and other related subjects, and shall interest itself in the work of voluntary health associations.

CHAPTER IX. ASSESSMENTS AND EXPENDITURES

Section 1. The annual dues for membership in this Association shall be as follows: (1) Active Members, $75, except Active Members who devote all of their time to teaching or research and have no private practice, $50.00; (2) Emeritus Members, no dues; (3) Associate Members, $8; (4) Inactive Members, $8; (5) Student Members, $1; (6) Honorary Members, no dues; (7) Special Members, no dues. Dues fixed by these Bylaws shall constitute assessments against the component societies. The Secretary of each component society shall forward its assessment together with its roster of all officers and members, list of delegates and list of non-affiliated physicians of the county to the Secretary of this Association as of the first day of January in each year.

Section 2. Any component society which fails to pay its assessments, or make the report as required, on or before the first day of April in each year, shall be held as suspended and none of its members or delegates shall be permitted to participate in any of the business or proceedings of the Association or of the House of Delegates until such requirements have been met.

Section 3. All motions and resolutions appropriating money shall specify a definite amount or so much thereof as may be necessary for the purpose, and must have prior approval of the Board of Trustees before they can become effective.

CHAPTER X. RULES OF CONDUCT

The principles set forth in the Principles of Ethics of the American Medical Association, together with the Constitution and Bylaws of the Association and all duly adopted resolutions of the House of Delegates, shall govern the conduct of members in their relation to each other and to the public.

CHAPTER XI. RULES OF ORDER

The deliberations of this Association shall be governed by parliamentary usage as contained in Robert's Rules of Order, unless otherwise determined by a vote of its respective bodies.

CHAPTER XII. COUNTY SOCIETIES

Section 1. Except as provided in Section 4 of this Chapter, all county medical societies in this state which have adopted principles of organization not in conflict with this Constitution and Bylaws shall, upon application to the House of Delegates, receive a charter from and become a component part of this Association.

Section 2. As rapidly as can be done after the adoption of this Constitution and Bylaws, a medical society shall be organized in every county in the state in which no component society exists, and charters shall be issued thereto.

Section 3. Charters shall be issued only upon approval of the House of Delegates and shall be signed by the President and Secretary. The House of Delegates shall have authority to revoke the charter of any component society whose actions are in conflict with the letter or spirit of this Constitution and Bylaws.

Section 4. Only one component society shall be chartered in any county except that the House of Delegates may issue a charter to one statewide society of worthy Negro physicians who are not members of any component society. Membership in the component society thus created shall entitle the members thereof to all the rights and benefits of membership in the Kentucky Medical Association.

Section 5. In sparsely settled sections two or more component societies may join for scientific programs, the election of officers, and such other matters as they may deem advisable. The component societies thus combined shall not lose any of their privileges or representation. The active members of each component society shall annually elect at least a Secretary and a Delegate for the transaction of its business with the Association.

Section 6. Each component society shall be the sole judge of the qualifications of its own members. All members of component societies shall be members of the Kentucky Medical Association, and shall be classified in accordance with Chapter I, Section 2 of these Bylaws. Provided, however, that no physician who is under suspension or who has been expelled shall thereafter, without reinstatement by the Board of Trustees be eligible for membership in any component society. Any physician who desires to become a member of the Kentucky Medical Association shall first apply to the component society in the county in which he resides, for membership therein. Except as hereinafter provided in Sections 7 and/or 9 of this chapter, no physician shall be an active member of a component society in any county other than the county in which he resides.

Section 7. Any physician who may feel aggrieved by the action of the component society of the county in which he resides, in refusing him membership, shall have the right to appeal to the Board of Trustees, which, upon a majority vote, may permit him to apply for membership in a component society in a county which is adjacent to the county in which he resides.

Section 8. When a member in good standing in a component society moves to another county in the State, his name, upon request, shall be transferred without cost to the roster of the component society into whose jurisdiction he moves, if he is admitted to membership therein.

Section 9. A physician whose residence is closer to the headquarters of an adjacent component society than it is to the headquarters of the component society of the county in which he resides, may, with the consent of the component society within whose jurisdiction he resides, hold membership in said adjacent component society.

Section 10. Each component society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, moral and material conditions of every physician in the county. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it embraces every qualified physician in the county.

Upon reasonable notice and after a hearing, component societies may discipline their members by censure, fine, suspension or expulsion, for any breach of the Principles of Medical Ethics or any bylaw, rule or regulation lawfully adopted by such societies or this Association. At every hearing, the accused shall be entitled to be represented by counsel and to cross-examine witnesses, and the society shall cause a stenographic record to be made of the entire proceedings. The stenographer's notes need not be transcribed unless and until requested by the respondent member.

Any physician aggrieved by the disciplinary action of a component society may, within ninety (90) days appeal to the Judicial Council, whose decision shall be final. This appeal shall be in writing and shall point out in detail the errors committed by the county society. It shall be accompanied by a transcript of the proceedings before the county society, procured at appellant's expense, and the statement of appeal shall direct the attention of the Judicial Council to those portions of the transcript upon which he relies.

Any member who fails or refuses to comply with the lawful disciplinary orders of his component society shall, if such failure or refusal continues for more than thirty (30) days, be automatically suspended from membership. Provided, however, that an appeal shall stay the suspension until a final decision is made by the Judicial Council.

The resignation of a member against whom disciplinary charges are pending or who is in default of the disciplinary judgment of his county society, a district grievance committee or the Board of Trustees shall not be accepted and no member who is suspended or expelled may be reinstated or readmitted unless and until he complies with all lawful orders of his component society and the Board of Trustees.

Section 11. Frequent meetings shall be encouraged, and the most attractive programs arranged that are possible. The younger members shall be especially encouraged to do postgraduate and original research work, and to give the society the first benefit of such labors. Official positions and other references shall be unstintingly given to such members.

Section 12. At the time of the annual election of officers, each component society shall elect a delegate or delegates to represent it in the House of Delegates. The term of a delegate shall commence on the first day of the regular session of the House following his election, and shall end on the day before the first day of the next regular session. Provided, however, that component societies may elect delegates for more than one term at any election. Each component society may elect one delegate for each 25 members in good standing, plus one delegate for one or more members in excess of multiples of 25. Provided, however that each component society shall be entitled to at least one delegate regardless of the number of members it may have and the secretary of the society shall send

a list of such delegates to the Secretary of this Association not later than 45 days before the next Annual Meeting. It shall be the obligation of a component society which elects delegates to serve more than one year, to provide the KMA Headquarters Office with a certified list of its delegates each year.

Section 13. The secretary of each component society shall keep a roster of its members and a list of non-affiliated licensed physicians of the county, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this State, and such other information as may be deemed necessary. He shall furnish an official report containing such information upon blanks supplied him for the purpose, to the Secretary of the Association, on the first day of January of each year, or as soon thereafter as possible, and at the same time the dues accruing from the annual assessment are sent in. In keeping such roster the secretary shall note any change in the personnel of the profession by death or by removal to or from the county, and in making his annual report he shall be certain to account for every physician who has lived in the county during the year.

Section 14. The secretary of each component society shall report to the Journal of the Kentucky Medical Association full minutes of each meeting and forward to it all scientific papers and discussions which the society shall consider worthy of publication.

CHAPTER XIII. AMENDMENTS

These Bylaws may be amended at any session of the House of Delegates by a two-thirds vote of all the delegates present at that session, after the amendment has laid on the table for one day.

THE JOURNAL

of the

KENTUCKY MEDICAL ASSOCIATION

Index to Volume 62—1964

Edited by Sam A. Overstreet, M.D.

Under the Supervision of the Board of Trustees

SCIENTIFIC ARTICLES

SCIENTIFIC ARTICLES LISTED BY AUTHORS

CASE DISCUSSIONS

EDITORIALS

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SPECIAL ARTICLES

SPECIAL ARTICLES LISTED BY AUTHOR

ORGANIZATION SECTION STORIES

Whatever the methodology used and whoever the physicians who wish to participate in the testing of drugs, all of the groups that are concerned—should be vigilant to see that no one steps beyond his qualifications in testing a drug. And they, together with the Association of American Medical Colleges, should see that the problem of studying drugs in humans is placed squarely before medical students and house officers and that more opportunities are provided for them to observe the effects of drugs on people.—Harry F. Dowling, M.D., in *J.A.M.A.*, 187:3 (Jan. 18) 1964.

I have yet to see any desk-bound administrator or full-time politician who knows as much about the needs of a body as does the person who attends that body on an individual basis hour after hour. Concern and caution are advisable, of course, for all-drug maker, drug prescriber, drug dispenser and drug user. But when lay judgment is substituted for professional judgment, when the sick refuse to take what is wisely prescribed, when consumer representatives and motivation hunters try to resolve medical problems without medical knowledge when the medical profession is notified of government interventions in drug use through the popular press rather than through normal professional channels, when the public received medical information about drug reactions before the profession is informed, the already ailing members of the public will suffer even more. In fact, they will suffer more than any other group since it will be their own bodies which are deprived of needed medical counseling and remedies. Austin Smith, M.D., in *Oklahoma Medical Journal,* 57: 8 (August) 1964.

With all the progress that has been made, much remains to be done. Medical research is still almost impotent against multiple sclerosis, cystic fibrosis, mongolism, muscular dystrophy and many other conditions. Fortnately, medical progress is being carried forward by contributions of basic knowledge by men and women in the life sciences. Indeed, all the life and social sciences are now being brought to bear on the control of disease and its consequences. There is every reason for confidence that the enemies of mankind's health will be overcome one by one in the future through the combined efforts of the entire medical team. The pharmaceutical industry anticipates with pride the part that it will play in the ultimate success.—Alfred E. Driscol, President, Warner-Lambert Pharmaceutical Company, in *New England Journal of Medicine,* 270: 6 (Feb. 6, 1964).

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JOURNAL OF THE KMA BUYERS GUIDE FOR DECEMBER, 1964

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Average adult dose: 1, or if needed, 2 tablets three times daily. *Precautions:* Observe patients periodically for increased intraocular pressure and barbiturate habituation or addiction. Caution drivers against possible drowsiness. *Side effects:* Dehydrocholic acid may cause transitory diarrhea; belladonna — blurred vision, dry mouth. *Contraindications:* Biliary tract obstruction, acute hepatitis, glaucoma, and prostatic hyperplasia. *Available through your regular supplier:* DECHOLIN-BB, bottles of 100 tablets. 72664

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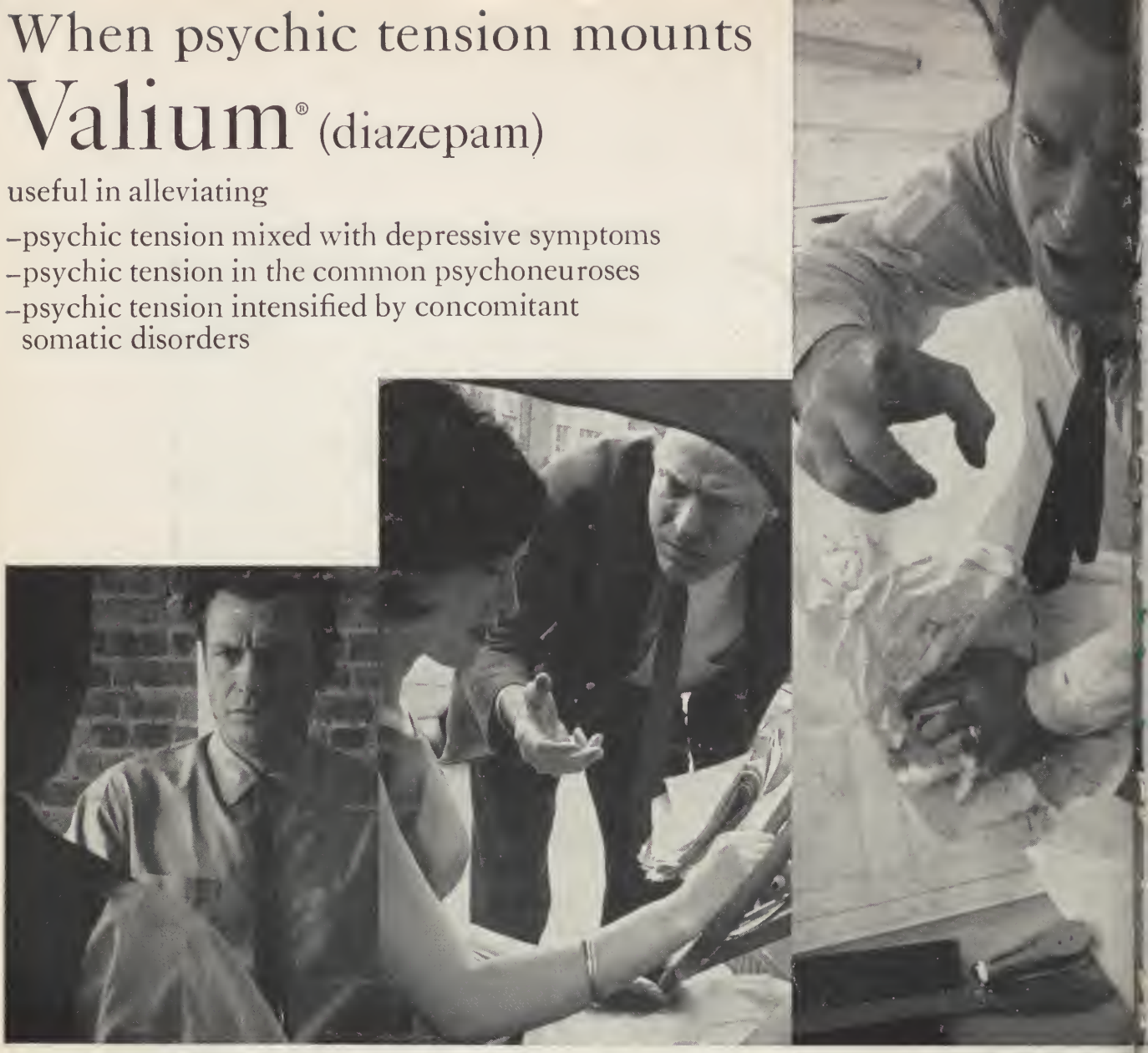

How to prescribe Valium (diazepam)

Indications: Valium (diazepam) is of use in dealing with anxiety reactions stemming from stressful circumstances or whenever somatic complaints are concomitants of emotional factors. It is useful in psychoneurotic states manifested by anxiety, tension, fear and fatigue.

Valium (diazepam) may also be useful in acute agitation due to alcohol withdrawal.

Valium (diazepam) may be of use to alleviate muscle spasm associated with cerebral palsy and athetosis.

Dosage and administration	*Usual daily dose*
Mild to moderate psychoneurotic reactions: Manifested by anxiety-tension alone or with depressive symptomatology, agitation, restlessness, psychophysiological disturbances	2 mg to 5 mg, 2 or 3 times daily
Severe psychoneurotic reactions: Where severe anxiety, fear, agitation, aggression or hostility exist alone or with depressive symptoms	5 mg to 10 mg, 3 or 4 times daily
Alcoholism: As an aid in symptomatic relief of acute agitation, tremor, impending or acute delirium tremens and hallucinosis	10 mg, 3 or 4 times during the first 24 hours; reducing to 5 mg, 3 or 4 times daily as needed
Muscle spasm associated with cerebral palsy or athetosis	2 mg to 10 mg, 3 or 4 times daily

Contraindications: Valium (diazepam) is contraindicated in infants, patients with a history of convulsive disorders or patients with a history of glaucoma.

Warning: Valium (diazepam) is not of value in the treatment of psychotic patients, and for this reason should not be employed in lieu of appropriate treatment.

Precautions: In elderly or debilitated patients, it is important to limit the dosage to the smallest effective amount to preclude the development of ataxia or oversedation (not more than 1 mg, 1 or 2 times daily initially, to be increased gradually as needed and tolerated). As is true of all CNS-acting drugs, until the correct maintenance dosage is established, patients receiving Valium (diazepam) should be advised against possibly hazardous procedures requiring complete mental alertness or physical coordination. Driving an automobile during the period of Valium (diazepam) therapy is not recommended. In general, the concurrent administration of Valium (diazepam) and other psychotropic agents is not recommended. If such combination therapy is used, careful consideration should be given to the pharmacology of the agents to be employed with Valium (diazepam)—particularly with known compounds which may potentiate the action of Valium (diazepam), such as phenothiazines, barbiturates, MAO inhibitors and other antidepressants.

Since Valium (diazepam) has a central nervous system depressant effect, patients should be advised against the simultaneous ingestion of alcohol and other central nervous system depressant drugs during Valium (diazepam) therapy. Safe use of Valium (diazepam) during pregnancy has not been established. The usual precautions are indicated when Valium (diazepam) is used in the treatment of anxiety states where there is any evidence of impending depression; particularly the recognition that suicidal tendencies may be present and protective measures may be necessary. The usual precautions in treating patients with impaired renal or hepatic function should be observed.

Side effects: In clinical use, fatigue, drowsiness and ataxia have been reported; in most instances these are dose-related and may be avoided by proper dosage adjustment. Mild nausea and dizziness may occur on occasion. As with any new agent, when it is administered for protracted periods of time, periodic blood counts and liver function tests are advisable. Abrupt cessation after prolonged overdosage may, in some patients, produce withdrawal symptoms (e.g., convulsions, tremor, abdominal and muscle cramps, vomiting, sweating) similar to those seen with barbiturates, meprobamate and Librium® (chlordiazepoxide HCl). Changes in EEG patterns have been observed in patients during and after Valium (diazepam) treatment.

Paradoxical reactions, such as excitement, depression, stimulation, sleep disturbances, acute hyperexcited states and hallucinations have been reported. Other side effects noted have been blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash.

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